STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495109	A. BUILDING _____ B. WING _____	C 05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF UNIVERSITY PARK	2420 PEMBERTON RD RICHMOND, VA 23233

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 05/10/2021 through 05/12/2021. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 5/10/2021 through 5/12/2021. Four complaints (VA00051762, VA00051214, and VA00051599- unsubstantiated without deficiency, VA00050776- substantiated with deficiency) were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 145 certified bed facility was 126 at the time of the survey. The survey sample consisted of 38 Resident reviews.	F 000		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is	F 622		6/15/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/27/2021

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endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record

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F 622	Continued From page 2 must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to evidence that the required information was provided to the receiving provider upon transfer to the hospital for two of 38 residents in the survey sample,	F 622	Resident's #71 and #333 have been returned to the facility. No negative outcome has occurred from this practice. All residents transferred to the hospital are potentially at risk.	

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F 622	Continued From page 3 Residents #71 and #333. The facility failed to evidence the comprehensive care plan goals were provided to the hospital for Resident #71's hospital transfer on 4/16/21, and for Resident #333's hospital on 3/9/21. The findings include: 1. Resident #71 was admitted to the facility on 3/20/21 and readmitted on 4/23/21 with the diagnoses of but not limited to acute respiratory failure, gastrostomy, below knee amputation (right), end stage renal disease, chronic obstructive pulmonary disease, deep vein thrombosis, dialysis, chronic kidney disease, dysphagia, aphasia, diabetes, depression, dementia, osteomyelitis, and COVID-19. The 5-day MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 4/28/21 coded the resident as severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing and toileting; extensive assistance for transfers, dressing, eating, and hygiene; and was incontinent of bowel and bladder. A review of the clinical record revealed a nurse's note dated 4/16/21 at 3:32 PM, which documented in part, "resident tolerated her medications this morning; about 15 minutes later, CNA (Certified Nursing Assistant) notified nurse that resident was c/o (complaining of) trouble breathing; brought resident her inhaler and it helped for a few minutes; CNA put pulse ox (oxygen) on resident on monitored, she notified nurse that resident's PO2 (pulse oxygen saturation) went down to 86%; put resident on	F 622	The DON or Designee will audit the last 14 days of hospital for appropriate documentation. Nursing administration will monitor documentation of hospital transfers 5 times daily for 4 weeks. Review of hospital transfers will remain a process during clinical operations meetings. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the Quality Assurance Committee. Continued compliance will be monitored through the quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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2lpm (two liters per minute) of O2 (oxygen); MD (medical doctor) was called and notified, MD said to send resident out to hospital; notified niece, (name) also 146/62 96.8 79 16 86%y (Blood pressure 146/62, temperature 96.8, pulse 79, respirations 16, and oxygen saturation 86%)."

There were no further nurse's notes written about this event prior to hospital transfer.

A review of the clinical record for Resident #71, revealed a "SNF/NF (skilled nursing facility/nursing facility) to Hospital Transfer Form" that was completed on 4/16/21. This form included resident demographic, medical, code status, functional status, and family contact, treatments, precautions, devices, allergies, and risk alert information. The form did not document any references to comprehensive care plan goals being provided.

As part of the above form was a page titled "Acute Care Transfer Document Checklist" that listed various documents to be sent with the resident. Each item contained a line next to it, to be checked off as being provided. Nothing was checked off. Also, the checklist did not contain reference for the provision of comprehensive care plan goals as an item to be sent to the hospital.

On 5/12/21 at 8:37 AM an interview was conducted with RN #4 (Registered Nurse) a unit manager. She stated that staff should send a facesheet, medication list, copy of the resident's code status, the care plan, and a bed hold policy. RN #4 stated it should be documented in the nurses note what all was sent. RN #4 reviewed the above identified transfer form and stated that it does not contain this information. She stated

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that if it was not documented in the nurse's note, then assume there is no evidence it was done.

On 5/12/21 at 10:58 AM an interview was conducted with LPN #1 (Licensed Practical Nurse), who wrote the above note. LPN #1 stated that at the time of this resident's transfer she was new to the facility and was not aware of all the process. She stated that she should have sent a bed hold, facesheet, medication list, recent labs [laboratory tests], code status, and care plan. LPN #1 stated, "I know now there was more stuff I was supposed to send but that was my second or third day on the unit." She stated that the unit manager who assisted with the transfer and paperwork was not there anymore. LPN #1 stated that there is a checklist but she did not see one. When asked how staff evidence what is sent, LPN #1 stated, "Document it." When asked if the nurse's note or transfer form evidenced that the care plan goals were sent, LPN #1 stated, "There is nothing in the note evidencing what was sent. There is a check list." When asked if the care plan goals was listed on the form, LPN #1 reviewed it and stated, "It is not on it." When asked, how do you know what all to send each time if it is not on the check list, LPN #1 stated, "The unit manager or person in charge are usually involved with the transfers."

A review of the facility's Admission / Transfer / Discharge policies that were provided did not address transfers/discharges in an emergent situation to the hospital and any associated procedures and requirements.

On 5/12/21 at 11:13 AM, ASM (Administrative Staff Member) #1, #2, #3, and #5 (the Administrator, the Director of Nursing, the

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Regional Director of Operations, and the Senior Clinical Transition Specialist) were made aware of the findings. No further information was provided.

2. Resident #333 was admitted to the facility on 2/15/21 and discharged to the hospital on 3/9/21 and did not return to the facility. The resident was admitted with the diagnoses of but not limited to left tibia fracture, pneumonia, obesity, diabetes, glaucoma, high blood pressure, chronic kidney disease, heart failure, end stage renal disease, dislocation of ankle joint, and dialysis. The 5-day MDS (Minimum Data Set) assessment, with an ARD (Assessment Reference Date) of 2/19/21 coded the resident as cognitively intact in ability to make daily life decisions. Resident #333 was coded as requiring total care for bathing; extensive assistance for transfers, dressing, toileting and hygiene; independent for eating; and was coded as occasionally incontinent of bowel and bladder.

A review of the clinical record for Resident #333 revealed the following notes in part:

- A nurse's note dated 3/9/21 at 2:00 PM documented, "Called MD (medical doctor) to notify him of the vital signs (temperature) 98.8, (blood pressure) 82/46, (pulse) 107, (oxygen saturation) level 89% on oxygen as ordered. Non-rebreather applied. Repeat (oxygen) level at 2:10pm is 75%. MD notified. Send patient out 911. RP (responsible party), daughter is aware."

- A nurse's note dated 3/9/21 at 3:09 PM documented, "This nurse observed guest as

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having a BS (blood sugar) of 57 nurse encouraged guest to drink some orange juice the aide assisted guest with her drink. upon getting a second set of BS it increased to 72. However guest was observed as having sob (shortness of breath) her O2 (oxygen) sats (saturation) were 89, oxygen was given at 5 liters and no improvement her vs (vital signs) (blood pressure) 82/46 (pulse) 107 O2 (oxygen saturation) 89 (temperature) 98.8. Patient primary was called Dr (doctor) (name) and he recommended that she be sent out to (name of) hospital verbal report was given, (Hospital nurse) the ER (Emergency Room) nurse stated she did not want the e-change of condition and e-interact transfer form to be faxed."

A review of the clinical record for Resident #333 revealed a "SNF/NF (skilled nursing facility/nursing facility) to Hospital Transfer Form" that was completed on 3/9/21. This form included resident demographic, medical, code status, functional status, and family contact, treatments, precautions, devices, allergies, and risk alert information. The form did not document any references to comprehensive care plan goals being provided.

As part of the above form was a page titled "Acute Care Transfer Document Checklist" that listed various documents to be sent with the resident. Each item contained a line next to it, to be checked off as being provided. Nothing was checked off. Also, the checklist did not contain reference for the provision of comprehensive care plan goals as an item to be sent to the hospital.

On 5/12/21 at 8:37 AM an interview was conducted with RN #4 (Registered Nurse) a unit

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manager. She stated that staff should send a facesheet, medication list, copy of the resident's code status, the care plan, and a bed hold policy. She stated it should be documented in the nurses note what all was sent. RN #4 reviewed the above identified transfer form and stated that it does not contain this information. She stated that if it was not documented in the nurse's note, then assume there is no evidence it was done.

The nurses involved in this hospital transfer were no longer at the facility and therefore could not be interviewed.

A review of the facility's Admission / Transfer / Discharge policies that were provided did not address transfers/discharges in an emergent situation to the hospital and any associated procedures and requirements.

On 5/12/21 at 11:13 AM, ASM (Administrative Staff Member) #1, #2, #3, and #5 (the Administrator, the Director of Nursing, the Regional Director of Operations, and the Senior Clinical Transition Specialist) were made aware of the findings. No further information was provided.

References:

1. Levaquin - is an antibiotic.
Information obtained from
https://medlineplus.gov/druginfo/meds/a697040.html

2. Albuterol - is a bronchodilator used to treat symptoms of lung diseases such as asthma and chronic obstructive pulmonary disease.
Information obtained from
https://medlineplus.gov/druginfo/meds/a607004.h

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	tml			
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)	F 623		6/15/21

§483.15(c)(3) Notice before transfer.
Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;

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(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy

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F 623	Continued From page 11 for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to evidence that the Ombudsman was notified of a hospital transfer for three of 38 residents in the survey sample, Residents #71, #333, and #138. The facility staff failed to evidence that notification of the transfer was provided to the ombudsman for Resident #71, transferred to the hospital on 4/16/21, Resident #33, transferred to the hospital on 3/9/21 and Resident #138, transferred to the hospital on 2/24/21. The findings include: 1. Resident #71 was admitted to the facility on	F 623	Residents #71, #333 and #138 were readmitted to the facility. No negative outcome occurred from this practice. All residents transferred to the hospital are potentially at risk. The administrator has in-serviced the Social Service Department of the requirement to notify the Office of the State Long-Term Care Ombudsman of hospital transfers and process for being able to provide evidence of this notification occurred. Social Service will notify the Long-Term Care Ombudsman office of the hospital transfers since January 1, 2021.	

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F 623	Continued From page 12 3/20/21 and readmitted on 4/23/21 with the diagnoses of but not limited to acute respiratory failure, gastrostomy, below knee amputation (right), end stage renal disease, chronic obstructive pulmonary disease, deep vein thrombosis, dialysis, chronic kidney disease, dysphagia, aphasia, diabetes, depression, dementia, osteomyelitis, and COVID-19. The 5-day MDS (Minimum Data Set) assessment, with an ARD (Assessment Reference Date) of 4/28/21 coded the resident as being severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing and toileting; extensive assistance for transfers, dressing, eating, and hygiene; and was incontinent of bowel and bladder. A review of the clinical record for Resident #71 revealed a nurse's note dated 4/16/21 at 3:32 PM that documented in part, "resident tolerated her medications this morning; about 15 minutes later, CNA (Certified Nursing Assistant) notified nurse that resident was c/o (complaining of) trouble breathing; brought resident her inhaler and it helped for a few minutes; CNA put pulse ox (oxygen) on resident on monitored, she notified nurse that resident's PO2 (pulse oxygen saturation) went down to 86%; put resident on 2lpm (two liters per minute) of O2 (oxygen); MD (medical doctor) was called and notified, MD said to send resident out to hospital; notified niece, (name) also 146/62 96.8 79 16 86%y (Blood pressure 146/62, temperature 96.8, pulse 79, respirations 16, and oxygen saturation 86%)." There were no further nurse's notes written about this event prior to hospital transfer.	F 623	The administrator will audit monthly for 3 months that notification of hospital transfers has been made to the Long-Term Care Ombudsman's office. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the Administrator/Designee to the quality assurance committee. Continued compliance will be monitored through the quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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F 623	Continued From page 13	F 623		

A review of the clinical record for Resident #71 revealed a "SNF/NF (skilled nursing facility/nursing facility) to Hospital Transfer Form" that was completed on 4/16/21. This form included resident demographic, medical, code status, functional status, and family contact, treatments, precautions, devices, allergies, and risk alert information. The form did not document any references to a written Ombudsman notice being provided.

On 5/12/21 at 8:37 AM an interview was conducted with RN #4 (Registered Nurse) a unit manager. She stated that nurses do not notify the Ombudsman.

On 5/12/21 at 10:02 in an interview with OSM #4 (Other Staff Member, the Social Worker), she stated that the Administrator does the Ombudsman notifications.

On 5/12/21 at 10:09 AM in an interview with ASM #1 (Administrative Staff Member, the Administrator), she stated that the social worker does the Ombudsman notifications.

A review of the facility's Admission / Transfer / Discharge policies that were provided did not address transfers/discharges in an emergent situation to the hospital and any associated procedures and requirements.

On 5/12/21 at 11:13 AM, ASM (Administrative Staff Member) #1, #2, #3, and #5 (the Administrator, the Director of Nursing, the Regional Director of Operations, and the Senior Clinical Transition Specialist) were made aware of the findings. No further information was provided.

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2. Resident #333 was admitted to the facility on 2/15/21 and discharged to the hospital on 3/9/21 and did not return to the facility. The resident was admitted with the diagnoses of but not limited to left tibia fracture, pneumonia, obesity, diabetes, glaucoma, high blood pressure, chronic kidney disease, heart failure, end stage renal disease, dislocation of ankle joint, and dialysis. The 5-day MDS (Minimum Data Set), assessment with an ARD (Assessment Reference Date) of 2/19/21 coded the resident as being cognitively intact in ability to make daily life decisions.

A review of the clinical record revealed in part the following notes:

- A nurse's note dated 3/9/21 at 2:00 PM documented, "Called MD (medical doctor) to notify him of the vital signs (temperature) 98.8, (blood pressure) 82/46, (pulse) 107, (oxygen saturation) level 89% on oxygen as ordered. Non-rebreather applied. Repeat (oxygen) level at 2:10pm is 75%. MD notified. Send patient out 911. RP (responsible party), daughter is aware."

- A nurse's note dated 3/9/21 at 3:09 PM documented, "This nurse observed guest as having a BS (blood sugar) of 57 nurse encouraged guest to drink some orange juice the aide assisted guest with her drink. upon getting a second set of BS it increased to 72. However guest was observed as having sob (shortness of breath) her O2 (oxygen) sats (saturation) were 89, oxygen was given at 5 liters and no improvement her vs (vital signs) (blood pressure) 82/46 (pulse) 107 O2 (oxygen saturation) 89 (temperature) 98.8. Patient primary was called

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Dr (doctor) (name) and he recommended that she be sent out to (name of) hospital verbal report was given, (Hospital nurse) the ER (Emergency Room) nurse stated she did not want the e-change of condition and e-interact transfer form to be faxed."

A review of the clinical record for Resident #333 revealed a "SNF/NF (skilled nursing facility/nursing facility) to Hospital Transfer Form" that was completed on 3/9/21. This form included resident demographic, medical, code status, functional status, and family contact, treatments, precautions, devices, allergies, and risk alert information. The form did not document any references to a written Ombudsman notice being provided.

On 5/12/21 at 8:37 AM an interview was conducted with RN #4 (Registered Nurse) a unit manager. She stated that nurses do not notify the Ombudsman.

On 5/12/21 at 10:02 in an interview with OSM #4 (Other Staff Member, the Social Worker), she stated that the Administrator does the Ombudsman notifications.

On 5/12/21 at 10:09 AM in an interview with ASM #1 (Administrative Staff Member, the Administrator), she stated that the social worker does the Ombudsman notifications.

A review of the facility's Admission / Transfer / Discharge policies that were provided did not address transfers/discharges in an emergent situation to the hospital and any associated procedures and requirements.

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On 5/12/21 at 11:13 AM, ASM (Administrative Staff Member) #1, #2, #3, and #5 (the Administrator, the Director of Nursing, the Regional Director of Operations, and the Senior Clinical Transition Specialist) were made aware of the findings. No further information was provided.

References:

1. Levaquin - is an antibiotic.
Information obtained from https://medlineplus.gov/druginfo/meds/a697040.html

2. Albuterol - is a bronchodilator used to treat symptoms of lung diseases such as asthma and chronic obstructive pulmonary disease.
Information obtained from https://medlineplus.gov/druginfo/meds/a607004.html

3. Resident #138 was admitted to the facility on 7/9/16. Resident #138's diagnoses included but were not limited to congestive heart failure, high blood pressure and acute respiratory failure. Resident #138's annual and five day Medicare minimum data set assessment with an assessment reference date of 1/11/21, coded the resident's cognition as severely impaired.

Resident #138 was discharged to the hospital on 2/24/21 for shortness of breath and a low oxygen level. Review of Resident #138's clinical record failed to reveal evidence that notification of the discharge was provided to the ombudsman.

On 5/12/21 at 10:01 a.m., an interview was

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F 623	Continued From page 17 conducted with OSM (other staff member) #4 (the director of social services). OSM #4 stated she did not notify the ombudsman of resident hospital discharges but the administrator did. On 5/12/21 at 10:10 a.m., an interview was conducted with ASM (administrative staff member) #1, the administrator. ASM #1 stated the director of social services faxed a monthly list of resident hospital discharges to the ombudsman. ASM #1 was asked to provide evidence that notification of Resident #138's hospital discharge on 2/24/21 was provided to the ombudsman. On 5/12/21 at 11:28 a.m., ASM #1 stated she could not provide the requested document and was made aware that this was a concern. No further information was presented prior to exit.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with	F 625		6/15/21

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F 625	Continued From page 18 paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to evidence that a written bed hold notice was provided to the resident and/or responsible party upon a hospital transfer for 2 of 38 residents in the survey sample; Residents #71 and #333. The facility staff failed to evidence that a written bed hold notice was provided to the resident and/or responsible party upon a hospital transfer for Resident #71 on 4/16/21, and for Resident #333 on 3/9/21. The findings include: 1. Resident #71 was admitted to the facility on 3/20/21 and readmitted on 4/23/21 with the diagnoses of but not limited to acute respiratory failure, gastrostomy, below knee amputation (right), end stage renal disease, chronic obstructive pulmonary disease, deep vein thrombosis, dialysis, chronic kidney disease, dysphagia, aphasia, diabetes, depression,	F 625	Resident's #71 and #333 have been returned to the facility. No negative outcome has occurred from this practice. All residents transferred to the hospital are potentially at risk. The DON or designee will educate licensed nursing staff on documentation required in the medical record for hospital transfer and documents required to be sent with the resident to the hospital. The DON or designee will audit the last 14 days of hospital transfers for appropriate documentation. Nursing administration will monitor documentation of hospital transfers daily for 5 times per week for 4 weeks. Review of hospital transfers will remain a process during clinical operations meetings. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to	

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dementia, osteomyelitis, and COVID-19. The 5-day MDS (Minimum Data Set) assessment, with an ARD (Assessment Reference Date) of 4/28/21 coded the resident as being severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing and toileting; extensive assistance for transfers, dressing, eating, and hygiene; and was incontinent of bowel and bladder.

A review of the clinical record for Resident #71 revealed a nurse's note dated 4/16/21 at 3:32 PM that documented in part, "resident tolerated her medications this morning; about 15 minutes later, CNA (Certified Nursing Assistant) notified nurse that resident was c/o (complaining of) trouble breathing; brought resident her inhaler and it helped for a few minutes; CNA put pulse ox (oxygen) on resident on monitored, she notified nurse that resident's PO2 (pulse oxygen saturation) went down to 86%; put resident on 2lpm (two liters per minute) of O2 (oxygen); MD (medical doctor) was called and notified, MD said to send resident out to hospital; notified niece, (name) also 146/62 96.8 79 16 86%y (Blood pressure 146/62, temperature 96.8, pulse 79, respirations 16, and oxygen saturation 86%)."

There were no further nurse's notes written about this event prior to hospital transfer.

A review of the clinical record for Resident #71 revealed a "SNF/NF (skilled nursing facility/nursing facility) to Hospital Transfer Form" that was completed on 4/16/21. This form included resident demographic, medical, code status, functional status, and family contact, treatments, precautions, devices, allergies, and

the Quality Assurance Committee.

Continued compliance will be monitored through the quality assurance program. Additional education and monitoring will be initiated for any identified concerns.

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risk alert information. The form did not document any references to a written bed hold notice being provided.

As part of the above form was a page titled "Acute Care Transfer Document Checklist" that listed various documents to be sent with the resident. Each item contained a line next to it, to be checked off as being provided. Nothing was checked off. Also, the checklist did not contain reference for the provision of a written bed hold notice as an item to be sent to the hospital.

On 5/12/21 at 8:37 AM an interview was conducted with RN #4 (Registered Nurse) a unit manager. She stated that staff should send a facesheet, medication list, copy of the resident's code status, the care plan, and a bed hold policy. She stated it should be documented in the nurses note what all was sent. RN #4 reviewed the above identified transfer form and stated that it does not contain this information. She stated that if it was not documented in the nurse's note, then assume there is no evidence it was done.

On 5/12/21 at 10:58 AM an interview was conducted with LPN #1 (Licensed Practical Nurse), who wrote the above note. She stated that at the time of this resident's transfer she was new to the facility and was not aware of all the process. She stated that she should have sent a bed hold, facesheet, medication list, recent labs, code status, and care plan. LPN #1 stated, "I know now there was more stuff I was supposed to send but that was my second or third day on the unit." She stated that the unit manager who assisted with the transfer and paperwork was not there anymore. LPN #1 stated that there is a checklist but she did not see one. When asked

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how staff evidence what was sent, LPN #1 stated, "Document it." When asked if the nurse's note or transfer form evidenced that the bed hold notice was sent, LPN #1 stated, "There is nothing in the note evidencing what was sent. There is a check list." When asked if the bed hold notice was included on the checklist, LPN #1 reviewed it and stated, "It is not on it." When asked, how staff know what to send each time if it is not on the check list, LPN #1 stated, "The unit manager or person in charge are usually involved with the transfers."

On 5/12/21 at 10:02 in an interview with OSM #4 (Other Staff Member, the Social Worker), she stated that the Admissions department handles Bed Holds.

On 5/12/21 at 10:09 AM in an interview with ASM #1 (Administrative Staff Member, the Administrator), she stated that a Bed Hold notice goes in the discharge packet upon transfer.

On 5/12/21 at 10:24 AM in an interview with OSM #5, the Admissions staff member, she stated that when a resident is sent to the hospital, she calls the emergency room and checks on the resident's status. OSM #5 stated she then calls the family to offer the Bed Hold. She stated that if they do want to do one there is a form they fill out and sign and for how many days. She stated that most decline it. OSM #5 stated that she thought they we were only to do it if they want the bed hold and sign the form. She stated that she does not maintain documentation that those who did not want it were offered. OSM #5 stated she calls every family for hospital transfers.

A review of the facility's Admission / Transfer /

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Discharge policies that were provided did not address transfers/discharges in an emergent situation to the hospital and any associated procedures and requirements.

On 5/12/21 at 11:13 AM, ASM (Administrative Staff Member) #1, #2, #3, and #5 (the Administrator, the Director of Nursing, the Regional Director of Operations, and the Senior Clinical Transition Specialist) were made aware of the findings. No further information was provided.

2. Resident #333 was admitted to the facility on 2/15/21 and discharged to the hospital on 3/9/21 and did not return to the facility. The resident was admitted with the diagnoses of but not limited to left tibia fracture, pneumonia, obesity, diabetes, glaucoma, high blood pressure, chronic kidney disease, heart failure, end stage renal disease, dislocation of ankle joint, and dialysis. The 5-day MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/19/21 coded the resident as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive assistance for transfers, dressing, toileting and hygiene; independent for eating; and was occasionally incontinent of bowel and bladder.

Resident #333 was admitted to the facility on 2/15/21 and discharged to the hospital on 3/9/21 and did not return to the facility. The resident was admitted with the diagnoses of but not limited to left tibia fracture, pneumonia, obesity, diabetes, glaucoma, high blood pressure, chronic kidney disease, heart failure, end stage renal disease,

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dislocation of ankle joint, and dialysis. The 5-day MDS (Minimum Data Set), assessment with an ARD (Assessment Reference Date) of 2/19/21 coded the resident as being cognitively intact in ability to make daily life decisions.

A review of the clinical record revealed in part the following notes:

- A nurse's note dated 3/9/21 at 2:00 PM documented, "Called MD (medical doctor) to notify him of the vital signs (temperature) 98.8, (blood pressure) 82/46, (pulse) 107, (oxygen saturation) level 89% on oxygen as ordered. Non-rebreather applied. Repeat (oxygen) level at 2:10pm is 75%. MD notified. Send patient out 911. RP (responsible party), daughter is aware."

- A nurse's note dated 3/9/21 at 3:09 PM documented, "This nurse observed guest as having a BS (blood sugar) of 57 nurse encouraged guest to drink some orange juice the aide assisted guest with her drink. upon getting a second set of BS it increased to 72. However guest was observed as having sob (shortness of breath) her O2 (oxygen) sats (saturation) were 89, oxygen was given at 5 liters and no improvement her vs (vital signs) (blood pressure) 82/46 (pulse) 107 O2 (oxygen saturation) 89 (temperature) 98.8. Patient primary was called Dr (doctor) (name) and he recommended that she be sent out to (name of) hospital verbal report was given, (Hospital nurse) the ER (Emergency Room) nurse stated she did not want the e-change of condition and e-interact transfer form to be faxed."

A review of the clinical record for Resident #333 revealed a "SNF/NF (skilled nursing

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facility/nursing facility) to Hospital Transfer Form" that was completed on 3/9/21. This form included resident demographic, medical, code status, functional status, and family contact, treatments, precautions, devices, allergies, and risk alert information. The form did not document any references to a written bed hold notice being provided.

As part of the above form was a page titled "Acute Care Transfer Document Checklist" that listed various documents to be sent with the resident. Each item contained a line next to it, to be checked off as being provided. Nothing was checked off. Also, the checklist did not contain reference for the provision of a written bed hold notice as an item to be sent to the hospital.

The nurses involved in this hospital transfer were no longer at the facility and therefore could not be interviewed.

On 5/12/21 at 8:37 AM an interview was conducted with RN #4 (Registered Nurse) a unit manager. She stated that staff should send a facesheet, medication list, copy of the resident's code status, the care plan, and a bed hold policy. She stated it should be documented in the nurses note what all was sent. RN #4 reviewed the above identified transfer form and stated that it does not contain this information. She stated that if it was not documented in the nurse's note, then assume there is no evidence it was done.

On 5/12/21 at 10:02 in an interview with OSM #4 (Other Staff Member, the Social Worker), she stated that the Admissions department handles Bed Holds.

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On 5/12/21 at 10:09 AM in an interview with ASM #1 (Administrative Staff Member, the Administrator), she stated that a Bed Hold notice goes in the discharge packet upon transfer.

On 5/12/21 at 10:24 AM in an interview with OSM #5, the Admissions staff member, she stated that when a resident is sent to the hospital, she calls the emergency room and checks on the resident's status. OSM #5 stated she then calls the family to offer the Bed Hold. She stated that if they do want to do one there is a form they fill out and sign and for how many days. She stated that most decline it. OSM #5 stated that she thought they we were only to do it if they want the bed hold and sign the form. She stated that she does not maintain documentation that those who did not want it were offered. OSM #5 stated she calls every family for hospital transfers.

A review of the facility's Admission / Transfer / Discharge policies that were provided did not address transfers/discharges in an emergent situation to the hospital and any associated procedures and requirements.

On 5/12/21 at 11:13 AM, ASM (Administrative Staff Member) #1, #2, #3, and #5 (the Administrator, the Director of Nursing, the Regional Director of Operations, and the Senior Clinical Transition Specialist) were made aware of the findings. No further information was provided.

References:

1. Levaquin - is an antibiotic. Information obtained from

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F 625	Continued From page 26 https://medlineplus.gov/druginfo/meds/a697040.html 2. Albuterol - is a bronchodilator used to treat symptoms of lung diseases such as asthma and chronic obstructive pulmonary disease. Information obtained from https://medlineplus.gov/druginfo/meds/a607004.html	F 625		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions.	F 636		6/15/21

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F 636	Continued From page 27 (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interview and facility document review, it was determined that the facility staff failed to code the annual MDS [minimum data set], with an ARD [assessment reference date] of 03/16/2021, for the use of oxygen for one of 38 residents in the	F 636	A corrected assessment was sent for Resident #58's MDS with ARD 3/16/21 to include the use of Oxygen. Residents on oxygen are potentially at risk.	

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F 636	Continued From page 28 survey sample, Resident # 58. The findings include: Resident # 58 was admitted to the facility with diagnoses that included but were not limited to: acute and chronic respiratory failure [1] and chronic obstructive pulmonary disease [2]. Resident # 58's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 03/16/2021, coded Resident # 58 as scoring an 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 - being cognitively intact for making daily decisions. Under section "O0100 Special Treatments, Procedures and Programs" it documented in part, "C. Oxygen therapy. 2. While a Resident." Further review of this section revealed the box under "2. While a Resident", was not checked. On 05/10/21 at 1:46 p.m., 05/11/21 at 7:57 a.m., and on 05/11/21 at 2:17 p.m., observations of Resident # 58 revealed the resident lying in bed receiving oxygen by nasal cannula from an oxygen concentrator. Observation of the flow meter on the oxygen concentrator revealed that Resident # 58 was receiving oxygen at three liters per minute. The POS [physician's order sheet' dated May 2021 for Resident # 58 documented, "O2 [oxygen] 4L [four liters] via [by] NC [nasal cannula] continuously. Start Date: 12/16/2019." On 05/11/2021 at 4:12 p.m. an interview was conducted with RN [registered nurse] # 3, MDS coordinator. When asked about the coding for	F 636	The regional MDS coordinator will educate MDS staff on appropriate coding on MDS. The MDS Coordinator reviewed residents with Oxygen to determine if appropriate order, if use was care planned and if most recent MDS is coded appropriately for use. Corrections will be made as identified. MDS Coordinator or designee will audit annual MDS weekly for 4 weeks, they every other week for 1 month for accuracy of MDS coding. Corrections will be made as identified. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/designee to the quality assurance committee. Continued compliance will be monitored through the quality assurance program. Additional education will be initiated for any identified concerns.	

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Resident # 58's use of oxygen on their annual MDS assessment dated 03/16/2021, RN # 3 stated they would review the MDS. On 05/12/2021 at 9:29 a.m., RN # 3 stated that Resident # 58's annual MDS was not coded for oxygen. When asked to describe the procedure for completing the MDS, RN # 3 stated that they follow the RAI [resident assessment manual.

CMS's (Centers of Medicare/Medicaid) RAI (resident assessment instrument) Version 3.0 Manual CH 3: MDS documented, "SECTION O: SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS. Intent: The intent of the items in this section is to identify any special treatments, procedures, and programs that the resident received during the specified time periods. O0100: Special Treatments, Procedures, and Programs. Facilities may code treatments, programs and procedures that the resident performed themselves independently or after set-up by facility staff. Do not code services that were provided solely in conjunction with a surgical procedure or diagnostic procedure, such as IV medications or ventilators. Surgical procedures include routine pre- and post-operative procedures."

On 05/12/2021 at approximately 11:15 a.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, ASM # 3, regional director of operations and ASM # 4, senior clinical transition specialist, were made aware of the above findings.

No further information was provided prior to exit.

References:
[1] When not enough oxygen passes from your

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F 636	Continued From page 30 lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html. [2] Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.	F 636		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission.	F 655		6/15/21

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F 655	Continued From page 31 (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, facility staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to implement a resident's initial baseline care plan for one of 38 residents reviewed, Resident #337. The facility staff failed to administer oxygen at the physician-prescribed rate, according to Resident #337's baseline care plan. The findings include: Resident #337 was admitted to the facility on 4/26/21 with diagnoses including COPD (1) and lung cancer. She had not been a resident of the facility long enough to have a completed MDS (minimum data set) assessment. On the Resident #337's admission nursing assessment dated 4/26/21, she was coded as being oriented to person, place, and time, and as receiving oxygen	F 655	A corrected order was obtained for Resident #337's oxygen and the baseline care plan was updated. Residents on oxygen are potentially at risk. The regional MDS Coordinator will educate MDS staff on development of care plan. The MDS coordinator reviewed resident with Oxygen to determine if appropriate order, if use was care planned and if most recent MDS is coded appropriately for use. Corrections will be made as identified. MDS Coordinator or designee will audit MDS reviews weekly for 4 weeks, then every other week for 1 month and then	

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F 655	Continued From page 32 at the rate of two liters per minute. On 5/11/21 at 9:53 a.m., Resident #337 was observed sitting up in bed. Her eyes were closed. Oxygen was being delivered to her from a concentrator through a nasal cannula. The middle of the ball on the concentrator flowmeter was observed between 3.5 and 4 liters per minute. During the observation, Resident #337 awoke and participated in an interview. She stated her oxygen rate should be four liters per minute, and that is the rate her doctor had ordered for her both at home, and after she was admitted to the facility. Resident #337 stated she had been receiving oxygen at 4 liters per minute ever since she was admitted. She stated she did not adjust the oxygen concentrator herself, and that a staff member had mentioned that the knob on the oxygen concentrator for adjusting the flow rate was broken. On 5/11/21 at 12:15 p.m., Resident #337 was observed sitting in a wheelchair eating lunch. Oxygen was being delivered to her from a concentrator through a nasal cannula. The middle of the ball on the oxygen concentrator flowmeter was observed between 3.5 and 4 liters per minute. On 5/11/21 at 2:50 p.m., Resident #337 was observed sitting in a wheelchair in her room. LPN #12 came into the room. When asked to state the rate of Resident #337's oxygen, LPN #1 stated, "Well, the top of the ball is on 4. The bottom of the ball is on 3.5. There is no knob to adjust it." LPN #12 was observed manipulating the knobs on the oxygen concentrator, and finally stated, "I fixed it. I moved it to 4. The line should go through the middle of the ball."	F 655	monthly for 1 month for accuracy of orders, development and accuracy of baseline care plan and/or Comprehensive Care Plan and accuracy of MDS coding. Corrections will be made as identified. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the quality assurance committee. Continued compliance will be monitored through the quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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A review of Resident #337's clinical record revealed the following oxygen orders:

- "4/27/21 Oxygen cont. (continuous) 2LPM (two liters per minute) via NC (nasal cannula) to keep sats (saturations) >92% (greater than 92%) every shift." This order was discontinued by LPN #12 at 3:00 p.m. on 5/11/21.

- "5/11/21 (at 3:00 p.m.) Oxygen cont. at 4 LPM via NC to keep sats >92% every shift." This order was entered by LPN #12.

A review of Resident #337's initial baseline care plan dated 4/26/21, revealed, in part: "[Resident #337] has a potential for difficulty breathing and risk for respiratory complications...Administer medications and treatments per physician orders...Oxygen."

On 5/11/21 at 2:11 p.m., RN (registered nurse) #3, the MDS nurse, was interviewed. When she asked the purpose of a resident's care plan, RN #3 stated the care plan tells the staff how to take care of a resident, and raises any issues that should be addressed while the resident is in the facility's care.

On 5/11/21 at 3:19 p.m., LPN #1 was interviewed. When asked the purpose of the care plan, she stated the care plan contains different tools that are in place to help the resident, and different interventions to assist the resident and keep the resident safe. She stated the care plan contains goals that can be set, measured, and evaluated. LPN #1 stated the goals are set in place in order for the resident to have the optimal outcome. When asked how she makes sure the care plan

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F 655	Continued From page 34 interventions are implemented, LPN #1 stated that many of the interventions "pop up" on the TAR for the staff to sign off as being completed. On 5/11/21 at 4:45 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing (DON), and ASM #3, the regional director of operations, were informed of these concerns. On 5/12/21 at 10:34 a.m., LPN #4, a unit manager, was interviewed. When asked how a resident's oxygen rate is determined, LPN #4 stated, "I will talk to the resident, then look through the orders." She stated an order from a physician, which includes the rate and method of delivery, is required to administer oxygen. On 5/12/21 at 10:58 a.m., ASM #2, the director of nursing was interviewed. She stated the physician's ordered rate should be followed. No further information was provided prior to exit. REFERENCES (1) COPD is "a general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis." Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 12	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the	F 656		6/15/21

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resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff

Resident #128: Physician orders for

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F 656	Continued From page 36 interview, facility document review, and clinical record review, it was determined that the facility staff failed to develop and/or implement the comprehensive care plan for six of 38 residents in the survey sample, Residents #128, #115, #15, #58, #63, and #57. The facility staff failed to implement the comprehensive care plan for: 1. Resident #128, for the administration of oxygen and a CPAP per a physician's order, 2. Resident #115, facility staff failed to implement her comprehensive care plan for her feeding tube, 3a. Resident # 15's, for the use of non-pharmacological interventions prior to the use of as needed pain medication of oxycodone [1]. b. The facility staff failed to develop a comprehensive care plan for Resident # 15's the use of physician ordered oxygen. 4a. The facility staff failed to implement Resident # 58's comprehensive care plan for the use of non-pharmacological interventions prior to the use of as needed pain medication of oxycodone [1]. b. The facility staff failed to implement the comprehensive care plan for Resident # 58's the use of physician ordered oxygen. 5. The facility staff failed to implement Resident # 63's comprehensive care plan for the use of non-pharmacological interventions prior to the use of as needed pain medication of acetaminophen [1].	F 656	Oxygen and CPAP machine have been clarified and written and the care plan has been updated to reflect this. No negative outcome occurred from this practice. Resident #115: Medication Administration Record was revised to include a designated place to record the "total amount taken in." Tube feeding and flush orders have been clarified. Comprehensive care plan has been updated. No negative outcome occurred from this practice. Resident #15: The Non-pharmacological interventions for PRN Oxycodone have been reviewed and staff have been educated on the documentation of non-pharmacological interventions prior to administration of PRN narcotic administration. Oxygen orders have been reviewed and revised and comprehensive care plan has been revised. No negative outcome occurred from either practice. Resident #58: The Non-pharmacological interventions for PRN pain medication have been reviewed and staff have been educated on the documentation of non-pharmacological interventions prior to administration of PRN pain medication administration. Oxygen orders have been reviewed and revised and comprehensive care plan has been revised. No negative outcome occurred from either practice. Resident #63: The non-pharmacological interventions for PRN pain medication have been reviewed and staff have been	

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F 656	Continued From page 37 6. The facility staff failed to develop a comprehensive care plan which included the use of bed rails for Resident #57. The findings include: 1. Resident #128 was admitted to the facility on 4/21/21 with diagnoses including, but not limited to, COPD (Chronic Obstructive Pulmonary Disease) (2) and heart failure. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 4/25/21, Resident #128 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). She was coded as receiving oxygen both before and while a resident at the facility. On 5/10/21 at 12:20 p.m., Resident #128 was observed sitting up in bed. She was receiving oxygen from a concentrator through a nasal cannula. The oxygen flowrate was set at 2 lpm (liters per minute). The oxygen tubing running from the concentrator to the resident did not have a date. When asked about the tubing, Resident #128 stated the tubing had not been changed since she had been admitted to the facility. On 5/10/21 at 4:00 p.m., Resident #128 was observed sitting up in bed. She was receiving oxygen from a concentrator through a nasal cannula. The oxygen flowrate was set at 2 lpm (liters per minute). On 5/11/21 at 9:18 a.m., Resident #128 was again asked about her oxygen tubing. She stated the tubing had still not been changed. At this	F 656	educated on the documentation of non-pharmacological interventions prior to administration of PRN medication. Resident #57: is no longer a resident at facility. All residents have the potential to be affected. DON or designee will educate licensed nursing staff on following the care plan interventions, checking oxygen settings with physicians orders, checking tube feeding settings for tube feeding and water flow rates per physician order, following devise assessment, orders and care plan for use of rails, and following non-pharmacological interventions for pain. The DON or designee will educated licensed nursing staff on following interventions on the resident care plans. This will also include education on ensuring O2 settings match orders as care planned, care plan are followed for non-pharmacological approaches, care plan are followed for side rail usage and care plans are followed for tube feeding orders. The DON or designee will audit 1. Current resident on O@ and their settings, 2. Current residents on tube feedings and their settings, 3. Residents with PRN pain medication, care plan interventions and documented	

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time, LPN (licensed practical nurse) #12 entered the room. LPN #12 was asked to identify the date the oxygen tubing had been changed. LPN #1 stated, "There is no date on the tubing." She stated since there was no date, she could not say when or if the tubing had been changed. Resident #128 stated, "The tubing hasn't been changed since I was admitted, and [the tubing] is hard." LPN #12 stated the tubing should be changed weekly, and it is usually changed on the weekends.

On 5/11/21 at 11:34 a.m., Resident #128 was observed lying in bed. She was wearing a CPAP device. She removed the device, replaced the nasal cannula so she could receive oxygen, and participated in an interview. She stated she has been receiving oxygen since before she was admitted to the facility, and has been receiving it ever since her admission to the facility. She further stated she uses the CPAP "all the time," including daytime naps as well as overnight sleep. When asked if the staff was providing any supervision or cleaning for the CPAP, she stated they were not.

Review of Resident #128's clinical record revealed an admission nursing assessment dated 4/21/21. The assessment documented: "Have you been told by a doctor that you have sleep apnea? Yes. Do you use a...CPAP? Yes. Do you use your machine regularly? Yes...Oxygen therapy? Yes. Oxygen therapy liter/min (liters per minute) and frequency? 2L (2 liters per minute)."

Review of Resident #128's clinical record revealed no physician's order for oxygen prior to 5/10/21, and no order at all for the sure of a CPAP. The review revealed the following order for

non-pharmacological intervention and 4. Residents with side rails, their devise assessment, orders and care plan. Corrections will be made based on findings.

Nursing administration will monitor 1. oxygen settings weekly for 4 weeks, 2. Tube feeding settings 5 times a week for 4 weeks, 3. Residents receiving PRN pain medications, non-pharmacological interventions will be reviewed weekly for 4 weeks, 4. Side rail orders and care plans and device assessment will be reviewed weekly for 4 weeks. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the quality Assurance Committee.

Continued compliance will be monitored through the quality assurance program. Additional education and monitoring will be initiated for any identified concerns.

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oxygen, dated 5/10/21at 11:00 p.m.: "Continuous oxygen @ (at) 2 liters every shift for sob (shortness of breath)."

A review of Resident #128's comprehensive care plan dated 4/22/21, revealed, in part: "[Resident #128] has a potential for difficulty breathing and risk for respiratory complications...Administer medications and treatments per physician orders...Oxygen, CPAP..."

On 5/11/21 at 2:11 p.m., RN (registered nurse) #3, the MDS nurse, was interviewed. When she asked the purpose of a resident's comprehensive care plan, RN #3 stated the care plan tells the staff how to take care of a resident, and raises any issues that should be addressed while the resident is in the facility's care.

On 5/11/21 at 3:10 p.m., LPN #6 was asked to verify Resident #128's oxygen rate set on the concentrator with her physician's order for oxygen. LPN #6 stated the oxygen rate matched the order. When asked when the oxygen order had been initially written, LPN #6 stated, "It looks like it was just written this morning." When asked if Resident #128 had been receiving oxygen prior to the morning of 5/11/21, LPN #6 stated, "Yes. She has had it the whole time." When asked if she could locate an order for oxygen for Resident #128 prior to 5/10/21, she stated she could not. When asked to locate the orders for Resident #128's CPAP, LPN #6 looked and stated, "An order for that does not pop up." When asked if a resident needed an order for a CPAP, she stated yes. When asked how often CPAP equipment needs cleaning, she stated she was not sure. LPN #6 stated, "Not every night, I don't think. Maybe every shift. I just really don't know."

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On 5/11/21 at 3:19 p.m., LPN #1 was interviewed. When asked the purpose of the comprehensive care plan, she stated the care plan contains different tools that are in place to help the resident, and different interventions to assist the resident and keep the resident safe. She stated the care plan contains goals that can be set, measured, and evaluated. She stated the goals are set in place in order for the resident to have the optimal outcome. When asked how she makes sure the care plan interventions are implemented, LPN #1 stated that many of the interventions "pop up" on the TAR for the staff to sign off as being completed.

On 5/11/21 at 4:45 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing (DON), and ASM #3, the regional director of operations, were informed of these concerns.

On 5/12/21 at 10:58 a.m., ASM #2, the director of nursing, was interviewed. She stated an order is required to administer oxygen to a resident. She stated an order is also required for a resident's CPAP usage. She stated the order should specify the settings on the machine.

A review of the facility policy, "Interdisciplinary Care Plan," revealed, in part, the following: "The Interdisciplinary Care Plan Team, in accordance with the guest, his/her family, or representative, develops and maintains a comprehensive care plan for each guest. The interdisciplinary care plan will: ...Reflect treatment goals and objectives in measurable outcomes ...Identify the professional services that are responsible for each element of care and frequency of services

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provided...Reflect the medical regimen and physician's plan of treatment."

2. Resident #115 was admitted to the facility on 4/9/21 with diagnoses including Parkinson's disease (1), dementia (2), and history of a stroke requiring the placement of a feeding tube (3). On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 4/13/21, she was coded as being severely cognitively impaired for making daily decisions, having scored three out of 15 on the BIMS (brief interview for mental status). Resident #115 was coded as receiving greater than 51% of her total calories through a feeding tube.

On the following dates and times, 5/11/21 at 9:58 a.m., 12:26 p.m., and 3:00 p.m., Resident #115 was observed lying in bed with the head her bed elevated. A tube feeding solution bag and a bag of water were hanging on a pole. Both feeding solution and the water were threaded through an automatic pump. The pump settings were 60 mls/hour (milliliters per hour) continuous for the tube feeding solution, and 40 mls of water one time flush each hour.

A review of Resident #115's clinical record revealed the following physician's orders, dated 4/21/21: "Jevity 1.2 (tube feeding solution) @ (at) 60 ml per hour...Jevity 1.2 at 60 ml per hour. Total amount taken in every night shift." The clinical record also contained the following physician's order: "Enteral (tube feeding) Feed Order Four times a day for Maintenance Flush PEG tube with 120 cc (cubic centimeters) of water."

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A review of Resident #115's MARs (medication administration records) and TARs (treatment administration records) revealed staff signatures for all dates in May 2021 for these orders, indicating the feedings and water were administered per the order. However, none of the night shift records contained a total amount of tube feeding solution taken in by the resident.

A review of Resident #115's comprehensive care plan, dated 4/14/21 and revised 4/19/21, revealed, in part: "[Resident #115] is unable to tolerate nutritionally adequate food and/or fluids by mouth requiring the use of a feeding tube...Administer tube feeding as ordered."

On 5/11/21 at 2:11 p.m., RN (registered nurse) #3, the MDS nurse, was interviewed. When she asked the purpose of a resident's comprehensive care plan, she stated the care plan tells the staff how to take care of a resident, and raises any issues that should be addressed while the resident is in the facility's care.

On 5/11/21 at 3:00 p.m., LPN (licensed practical nurse) #6 was accompanied to observe Resident #115's feeding tube pump settings. When asked to describe the settings, LPN #6 stated it was set to deliver 60 mls of Jevity each hour to the resident via the resident's feeding tube. She stated it was set to deliver a once-an-hour flush of 40 mls of water. When asked if she knew if these settings matched the physician's order, LPN #6 stated she thought so, but would need to verify. LPN #6 checked Resident #115's physician's orders, and stated, "I can't tell." She stated she thought that when the pump was programmed for the tube feeding solution, the pump automatically provided the 40 mls of water flush each shift. She

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stated: "No - the orders don't match what the pump is doing." She stated she did not know how to prevent the pump from delivering the 40 mls of water flush each hour.

On 5/11/21 at 3:19 p.m., LPN #1 was interviewed. When asked the purpose of the comprehensive care plan, she stated the care plan contains different tools that are in place to help the resident, and different interventions to assist the resident and keep the resident safe. She stated the care plan contains goals that can be set, measured, and evaluated. She stated the goals are set in place in order for the resident to have the optimal outcome. When asked how she makes sure the care plan interventions are implemented, LPN #1 stated that many of the interventions "pop up" on the TAR for the staff to sign off as being completed.

On 5/11/21 at 4:45 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing (DON), and ASM #3, the regional director of operations, were informed of these concerns.

On 5/12/21 at 10:34 a.m., LPN #4, a unit manager, was interviewed. She stated she was very familiar with the programming and operations of the feeding tube pumps. She stated the pumps are programmed according to the physician's orders. LPN #4 stated, "We always have to set the tube feeding and water amounts manually." She stated the tube feeding and flush amounts vary for each resident, and are adjusted as the resident's needs or conditions change. When asked to review Resident #115's TARs for the total amount of intake each night shift, LPN #4 stated, "They are missing a prompt. There

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should be an amount each shift. You can't just sign it off."

On 5/12/21 at 10:58 a.m., ASM #2 was interviewed. She verified that the tube feeding pumps must be manually programmed for both the tube feeding and the water amounts and rates, and that Resident #115's pump had been incorrectly programmed. ASM #2 stated the night shift staff should have been recording the total amount of tube feeding and water taken in by the resident for each preceding 24 hour period.

No further information was provided prior to exit.

REFERENCES
(1) "Parkinson's disease (PD) is a type of movement disorder. It happens when nerve cells in the brain don't produce enough of a brain chemical called dopamine. Sometimes it is genetic, but most cases do not seem to run in families." This information is taken from the website https://medlineplus.gov/parkinsonsdisease.html.

(2) "Dementia is a gradual and permanent loss of brain function. This occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior." This information is taken from the website https://medlineplus.gov/ency/article/000746.htm.

(3) "A PEG (percutaneous endoscopic gastrostomy) feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach. PEG feeding tube insertion is done in part using a procedure called endoscopy. Feeding tubes are needed when you are unable

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to eat or drink. This may be due to stroke or other brain injury, problems with the esophagus, surgery of the head and neck, or other conditions." This information is taken from the website https://medlineplus.gov/ency/patientinstructions/000900.htm

3a. Resident # 15 was admitted to the facility with diagnoses that include but not limited to: spinal stenosis [2].

Resident # 15's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 02/05/2021, coded Resident # 15 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Section "J0300, J0400 and J0600 Pain Assessment Interview" coded Resident # 15 as not having pain in the past five days`.

The physician's order for Resident # 15 dated 02/02/2021 documented, "Oxycodone Tablet 5 MG [five milligrams]. Give 1 [one] tablet by mouth every 6 [six] hours as needed for pain, pain scale 6-10 [six to ten]. Order Date: 2/2/2021."

Resident # 15's eMAR [electronic medication administration record] dated April 2021 documented the physician's order above. The eMAR failed to evidence documentation of non-pharmacological interventions prior to the administration of oxycodone on: 04/01/2021 at 12:13 p.m. with a level of six, 04/02/2021 at 12:42 p.m. with a pain level of seven, 04/04/2021 at 8:38 a.m. with a pain level of seven, 04/05/2021 at 1:03 p.m. with a pain level of six and at 10:10

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p.m. with a pain level of seven, 04/06/2021 at 1:19 p.m. with a pain level of seven, 04/07/2021 at 12:44 p.m. with a pain level of six, 04/10/2021 at 12:57 p.m. with a pain level of seven and at 9:41 p.m. with a pain level of seven, 04/14/2021 at 12:46 p.m. with a pain level of six, 04/15/2021 at 4:13 p.m. with a pain level of ten, 04/18/2021 at 3:45 a.m. with a pain level of six, 04/21/2021 at 5:55 a.m. with a pain level of eight, 04/24/2021 at 10:28 a.m. with a pain level of seven and at 10:14 p.m. with a pain level of eight, 04/25/2021 at 4:03 p.m. with a pain level of seven and on 04/27/2021 at 10:28 p.m. with a pain level of eight.

Resident # 15's eMAR [electronic medication administration record] dated May 2021 documented the above physician's order. The eMAR failed to evidence documentation of non-pharmacological interventions prior to the administration of oxycodone on: 05/04/2021 at 3:15 p.m. with a pain level of seven, 05/05/2021 at 10:20 p.m. with a pain level of six and on 05/09/2021 at 4:15 p.m. with a pain level of eight and at 10:11 p.m. with a pain level of seven.

The comprehensive care plan for Resident # 15 dated 07/16/2020 documented in part, "Need: [Resident # 15 is at risk for pain and/or has acute/chronic pain r/t [related to] Arthritis, spinal stenosis. Date Initiated: 07/16/2020." Under "Interventions" it documented in part, "Offer Non-Pharmacological Interventions: 1) Massage. 2) Meditation/Relaxation. 3) Positioning. 4) Ice/cold pack. 5) Diversional Activity. 6) Guided Imagery. 7) Rest. 8) Social Interaction. 9) Other. Date Initiated: 07/16/2020"

On 05/10/21 at 1:56 p.m., an interview was conducted with Resident # 15. When asked if

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they received pain medication when needed, Resident # 15 stated yes. When asked if the nurses try to alleviate the pain before administering the medication, Resident # 15 stated, "Sometimes they do."

On 05/11/21 at 2:27 p.m., an interview was conducted with LPN [licensed practical nurse] # 4, unit manager about implementing Resident # 15's comprehensive care plan for non-pharmacological interventions. When asked where a nurse documents that non-pharmacological interventions were attempted prior to administering an as needed pain medication, LPN # 4 stated, "Should be documented on the ear." After reviewing Resident # 15's April 2021 and May 2021 ears, LPN # 4 stated that there was missing documentation of non-pharmacological interventions on the dates and times documented above. LPN # 4 further stated that they couldn't say that the interventions were being attempted. When asked to review Resident # 15's comprehensive care plan, LPN # 4 stated that they didn't need to because they knew that the non-pharmacological interventions were on the care plan. LPN # 4 further stated that if the non-pharmacological interventions were not being done the care plan was not being followed.

On 05/11/2021 at approximately 4:45 a.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, and ASM # 3, regional director of operations, were made aware of the above findings.

No further information was provided prior to exit.

References:

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[1] Indicated for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=f2137f1a-b49a-40bd-97ac-cd6b36e295f4.

[2] A narrowing of the spinal column that causes pressure on the spinal cord, or narrowing of the openings (called neural foramina) where spinal nerves leave the spinal column. This information was obtained from the website: https://medlineplus.gov/ency/article/000441.htm.

3b. Resident # 15's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 02/05/2021, coded Resident # 15 for "Oxygen Therapy" while a resident in Section "O Special Treatments, Procedures and Programs."

On 05/10/21 at 11:02 a.m., and at 1:58 p.m., observation of Resident # 15 revealed they were sitting in their wheelchair receiving oxygen by nasal cannula from an oxygen concentrator. Observation of the flow meter on the oxygen concentrator revealed that Resident # 15 was receiving oxygen at two-and-a-half liters per minute.

On 05/11/21 at 7:58 a.m., an observation of Resident # 15 revealed the resident lying in bed receiving oxygen by nasal cannula connected to an oxygen concentrator. Observation of the flow meter on the oxygen concentrator revealed that Resident # 15 was receiving oxygen at two-and-a-half liters per minute.

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The physician's order dated 02/01/2021 for Resident # 15 documented, "Oxygen 2l/m [two liters per minute] via [by] nasal cannula [1] as needed for SOB [shortness of breath]."

The comprehensive care plan for Resident # 15 with a revision date of 02/01/2021 failed to evidence documentation for the use of oxygen.

On 05/11/2021 at 4:12 p.m. an interview was conducted with RN [registered nurse] # 3, MDS coordinator. When asked about the comprehensive care plan for Resident # 15's use of oxygen, RN # 3 stated they would review the care plan. On 05/12/2021 at 9:29 a.m., RN # 3 stated that care plan was developed for Resident # 15's use of oxygen.

On 05/11/2021 at 12:00 p.m. an interview was conducted with RN [registered nurse] # 3, MDS coordinator. When asked to describe the procedure for developing a resident's comprehensive care plan, RN # 3 stated that at the time of admission they look at the resident's diagnoses codes, the hospital history & physical, and physician's orders to develop the care plan. When asked how they maintain an accurate comprehensive care plan after admission, RN # 3 stated that they check the resident's physician's orders daily to develop, revise or update the care plan.

On 05/12/2021 at approximately 11:15 a.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, ASM # 3, regional director of operations and ASM # 4, senior clinical transition specialist, were made aware of the above findings.

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No further information was provided prior to exit.

4a. Resident # 58 was admitted to the facility with diagnoses that included but were not limited to: lower back pain.
Resident # 58's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 03/16/2021, coded Resident # 58 as scoring an 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 - being cognitively intact for making daily decisions. Section "J0300, J0400 and J0600 Pain Assessment Interview" coded Resident # 58 as having frequent pain at a level four based on a zero to ten pain scale, with ten being the worse pain they could imagine.

The physician's order for Resident # 58 dated 01/14/2020 documented, "Oxycodone Tablet 5 MG [five milligrams]. Give 5 mg by mouth every 6 [six] hours as needed for severe pain. Order Date: 1/14/2020."

The comprehensive care plan for Resident # 58 dated 07/16/2020 documented in part, "Need: [Resident # 58] has the potential for pain and general discomfort. Dx [diagnosis] of arthritis. Date initiated 05/04/2020." Under "Interventions" it documented in part, "Notify physician if interventions are unsuccessful or if current complaint is a significant change from resident's past experience of pain. Date initiated 05/04/2020."

Resident # 58's eMAR [electronic medication administration record] dated April 2021 documented the above physician's order for pain

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medication. The eMAR failed to evidence documentation of non-pharmacological interventions prior to the administration of oxycodone on: 04/09/2021 at 5:49 a.m. with a pain level of ten and on 04/19/2021 at 9:17 p.m. with a pain level of five.

Resident # 58's eMAR [electronic medication administration record] dated May 2021 documented the above physician's order for pain medication. The eMAR failed to evidence documentation of non-pharmacological interventions prior to the administration of oxycodone on: 05/04/2021 at 9:20 p.m. with a pain level of seven and on 05/08/2021 at 10:02 p.m. with a pain level of seven.

On 05/10/21 at 1:44 p.m., an interview was conducted with Resident # 58. When asked if they received pain medication when needed, Resident # 58 stated yes. When asked if the nurses try to alleviate the pain before administering the medication, Resident # 58 stated, "Sometimes they do sometimes they don't."

On 05/11/21 at 2:27 p.m., an interview was conducted with LPN [licensed practical nurse] # 4, unit manager about implementing Resident # 15's comprehensive care plan for non-pharmacological interventions. When asked where a nurse documents that non-pharmacological interventions were attempted prior to administering a as needed pain medication, LPN # 4 stated, "Should be documented on the eMAR." After reviewing Resident # 15's April 2021 and May 2021 eMARs, LPN # 4 stated that there was missing documentation of non-pharmacological

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interventions on the dates and times documented above. LPN # 4 further stated that they couldn't say that the interventions were being attempted. When asked to review Resident # 15's care plan LPN # 4 stated that they didn't need to because they knew that the non-pharmacological interventions were on the care plan. LPN # 4 further stated that if the non-pharmacological interventions were not being done the care plan was not being followed.

On 05/11/2021 at approximately 4:45 a.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, and ASM # 3, regional director of operations, were made aware of the above findings.

No further information was provided prior to exit.

References:
[1] Indicated for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=f2137f1a-b49a-40bd-97ac-cd6b36e295f4.

4b. On 05/10/21 at 1:46 p.m., 05/11/21 at 7:57 a.m., and at 2:17 p.m., observations of Resident # 58 revealed the resident lying in bed receiving oxygen by nasal cannula from an oxygen concentrator. Observation of the flow meter on the oxygen concentrator revealed that Resident # 58 was receiving oxygen at three liters per minute.

The POS [physician's order sheet' dated May

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2021 for Resident # 58 documented, "O2 [oxygen] 4L [four liters] via [by] NC [nasal cannula] continuously. Start Date: 12/16/2019."

The comprehensive care plan for Resident # 58 dated 12/24/2019 documented in part, "Need: [Resident # 58] has a potential for difficulty breathing and risk for respiratory complications R/T [related to]: Chronic Obstructive Pulmonary Disease, COPD, Requires the use of: O2 @ [at] 4 liters. Date Initiated: 12/24/2019." Under "Intervention" it documented in part, "Administer medication & [and] treatments per physician's orders. Monitor for ineffectiveness, side effects and adverse reactions, report abnormal finds to the physician. Guest to use Oxygen via nasal cannula. Date Initiated: 12/24/2019."

On 05/11/21 at 2:11 p.m., an interview was conducted with LPN [licensed practical nurse] # 4, unit manager. At 2:17 p.m., LPN # 4 was accompanied to Resident #58's room and was asked to read the oxygen flow rate on Resident # 58's oxygen concentrator. After entering Resident # 58's room and reading the flow meter LPN # 4 stated, "It's at three liters." When asked what the physician ordered the oxygen flow rate to be set at, LPN # 4 referred to the physician's orders and stated that it should set at four liters per minute. When asked if Resident # 58's comprehensive care plan was being implemented correctly, LPN # 4 stated, "It's not being followed."

On 05/11/2021 at approximately 4:45 a.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, and ASM # 3, regional director of operations, were made aware of the above findings.

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F 656	Continued From page 54 No further information was provided prior to exit. 5. Resident # 63 was admitted to the facility with diagnoses that included but were not limited to: fracture of the tibia [2]. Resident # 63's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 03/21/2021, coded Resident # 63 as scoring an 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 - being cognitively intact for making daily decisions. Section "J0300, J0400 and J0600 Pain Assessment Interview" coded Resident # 63 as having frequent pain at a level seven based on a zero to ten pain scale, with ten being the worse pain they could imagine. The physician's order for Resident # 63 dated 03/16/2021 documented, "Acetaminophen Tablet 325 MG [five milligrams]. Give 2 [two] tablets by mouth every 4 [four] hours as needed for severe pain and Give 2 tablets by mouth every 4 hours as needed for Temp [temperature 100F [One hundred degrees Fahrenheit] or above Order Date: 3/16/2021 ." The comprehensive care plan for Resident # 63 dated 03/16/2021 documented in part, "Need: [Resident # 63] is at risk for pain and/or has acute/chronic pain r/t [related to] recent falls, tibia fracture. Date Initiated: 03/16/2021." Under "Interventions" in documented in part, "Offer Non-Pharmacological Interventions: 1) Massage. 2) Meditation/Relaxation. 3) Positioning. 4) Ice/cold pack. 5) Diversional Activity. 6) Guided Imagery. 7) Rest. 8) Social Interaction. 9) Other. Date Initiated: 03/16/2021."	F 656		

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Resident # 63's ear [electronic medication administration record] dated April 2021 documented the physician's order as stated above. The ear failed to evidence documentation of non-pharmacological interventions prior to the administration of oxycodone on: 04/02/2021 at 6:04 p.m. with a pain level of eight, 04/04/2021 at 11:23 a.m. with a pain level of six and at 8:40 p.m. with a pain level of five, 04/08/2021 at 9:14 a.m. with a pain level of eight, 04/10/2021 at 9:38 a.m. with a pain level of six and at 3:51 p.m. with a pain level of six, 04/11/2021 at 5:25 p.m. with a pain level of five, 04/13/2021 at 1:39 p.m. with a pain level of eight, 04/ 14/2021 at 8:17 a.m. with a pain level of six, 04/15/2021 at 10:38 a.m. with a pain level of five, 04/16/2021 at 9:15 p.m. with a pain level of five, 04/19/2021 at 9:21 a.m. with a pain level of seven, 04/22/2021 at 4:38 p.m. with a pain level of three, 04/ 23/2021 at 10:47 a.m. with a pain level of four and at 6:22 p.m. with a pain level of seven, 04/24/2021 at 10:55 a.m. with a pain level of seven. Further review of the ear revealed that Resident # 63 did not receive acetaminophen for temperature over 100 degrees.

On 05/10/21 at 11:16 a.m., an interview was conducted with Resident # 63. When asked if they received pain medication when needed Resident # 63 stated yes. When asked if the nurses try to alleviate the pain before administering the medication Resident # 63 stated," No they just give me the medication."

On 05/11/21 at 2:27 p.m., an interview was conducted with LPN [licensed practical nurse] # 4, unit manager about implementing Resident # 63's comprehensive care plan for non-pharmacological interventions. When asked

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where a nurse documents that non-pharmacological interventions were attempted prior to administering a as needed pain medication, LPN # 4 stated, "Should be documented on the ear." After reviewing Resident # 63's April 2021 and May 2021 ears LPN # 4 stated that there was missing documentation of non-pharmacological interventions on the dates and times documented above. LPN # 4 further stated that they couldn't say that the interventions were being attempted. When asked to review Resident # 63's care plan LPN # 4 stated that they didn't need to because they knew that the non-pharmacological interventions were on the care plan. LPN # 4 further stated that if the non-pharmacological interventions were not being done the care plan was not being followed.

On 05/11/2021 at approximately 4:45 a.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, and ASM # 3, regional director of operations, were made aware of the above findings.

No further information was provided prior to exit.

References:
[1] Used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). This information was obtained from the website: https: https://medlineplus.gov/druginfo/meds/a681004.html.

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[2] The tibia is the larger of two long bones in the lower leg. It is sometimes called the shin bone. This information was obtained from the website: https://medlineplus.gov/ency/article/002335.htm.
6. Resident #57 was admitted to the facility with diagnoses that included but were not limited to metabolic encephalopathy (1), dementia (2) and osteoarthritis (3). Resident #57's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/15/2021, coded Resident #57 as scoring a 3 (three) on the staff assessment for mental status (BIMS) with a score of 0 - 15, 3- being severely impaired for making daily decisions. Section G coded Resident #57 as requiring extensive assistance of two or more staff for bed mobility, transfers and dressing.

On 5/10/2021 at approximately 11:50 a.m., Resident #57 was observed in bed with bilateral upper bed rails in place on the bed. The bed rails were observed up and Resident #57 was observed grasping the bed rail when turning to the side in bed. An interview was attempted with Resident #57, however Resident #57 failed to answer questions appropriately.

Additional observations of Resident #57 on 5/10/2021 at approximately 4:15 p.m. and 5/11/2021 at approximately 8:30 a.m. revealed the resident in bed with bilateral bed rails up.

The physician orders for Resident #57 failed to evidence an order for the use of bed rails.

The comprehensive care plan for Resident #57 dated "3/11/2021" failed to evidence documentation for use of bed rails.

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Review of Resident #57's clinical record failed to evidence a physical device assessment or consent for use of bed rails.

On 5/11/2021 at approximately 11:30 a.m., ASM (administrative staff member) #1, the administrator provided via email, documentation of bed rail inspections completed in the facility for the past twelve months. The document provided documented the bed in Resident #57's room having bed rails being inspected by maintenance staff on "Week 4 June 2020."

On 5/12/2021 at approximately 7:45 a.m., a request was made via a written list to ASM #1, for the physical device assessment, consent for bed rail use and care plan for use of bed rails for Resident #57.

On 5/12/2021 at approximately 9:30 a.m., ASM #1 stated that there was no order, consent or assessment for the bed rails for Resident #57. ASM #1 stated that Resident #57 should not have had the bed rails and they had no documentation to provide.

On 5/12/2021 at approximately 10:33 a.m., an interview was conducted with LPN (licensed practical nurse) #4, the unit manager. LPN #4 stated that residents were evaluated for the use of bed rails to determine if they were able to use them for repositioning or turning in bed. LPN #4 stated that if a resident were assessed as eligible for bed rails they discussed the risks and benefits of the use and if they agreed to have them, they would sign a consent to authorize them. LPN #4 stated that if the resident were unable to make the decision for bed rails they discussed them

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with the responsible party and had them sign the consent for use. LPN #4 stated that after the assessment was completed and the consent was obtained they obtained a physician order for the bed rails and had the bed rails put into use. LPN #4 stated that they would care plan the bed rails at that time. When asked the purpose of the comprehensive care plan, LPN #4 stated that it notified everyone what was going on with the resident at that time. LPN #4 stated that other staff were able to review the care plan to get an idea of the care that the resident required.

On 5/12/2021 at approximately 11:15 a.m., a request was made to ASM #1 for the facility policy on use of bed rails.

The facility policy, "Restraint Management" dated "Revised: 10/2019" documented in part, "... 1. Whenever a guest/resident is admitted with an order for a restraint (including side rails), the staff may accept the order for up to 72 hours pending completion of the Physical Device Evaluation. 2. When a guest's/resident's condition necessitates consideration for a restraint, alternative interventions must be attempted and documented on the Physical Device Evaluation and in the care plan...5. Any guest/resident using a physical restraint or side rails must have a current, signed restraint consent in the medical record..." The policy further documented, "...10. Any guest using side rails will have a current order with the following components: Type of side rails (1/2, 3/4, full, assist bars); Number of side rails to be raised; Reason for use/medical symptom; Guest/resident request for use of side rails (If applicable)..."

On 5/12/2021 at approximately 11:15 a.m., ASM

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F 656	Continued From page 60 #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of operations and ASM #5, the senior clinical transition specialist were made aware of the findings. No further information was provided prior to exit. Reference: 1. Encephalopathy- "Encephalopathy is a general term describing a disease that affects the function or structure of your brain." This information is taken from the website https://www.healthline.com/health/hepatic-encephalopathy. 2. Dementia is a loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm. 3. Osteoarthiris- Osteoarthritis occurs when cartilage, the tissue that cushions the ends of the bones within the joints, breaks down and wears away. In some cases, all of the cartilage may wear away, leaving bones that rub up against each other. This information was obtained from the website: https://www.nia.nih.gov/health/osteoarthritis.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of	F 657		6/15/21

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F 657	Continued From page 61 the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review it was determined that the facility staff failed to revise the comprehensive care plan for one of 38 residents in the survey sample, Resident #57. Resident #57's comprehensive care plan was not revised to address a significant weight loss. The findings include: Resident #57 was admitted to the facility with diagnoses that included but were not limited to metabolic encephalopathy (1), dementia (2) and osteoarthritis (3). Resident #57's most recent	F 657	Resident number 57 had a planned discharge to hospice level of care. No negative out come occurred from this practice. Residents with significant weight changes are potentially affected. The DON/designee will provide education on "Residents at Risk" Review to the interdisciplinary team that would include care plan updates to current clinical status.	

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F 657	Continued From page 62 MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/15/2021, coded Resident #57 as scoring a 3 (three) on the staff assessment for mental status (BIMS) with a score of 0 - 15, 3- being severely impaired for making daily decisions. Section G coded Resident #57, as requiring extensive assistance of two or more staff for bed mobility, transfers and dressing. Section K coded Resident #57 as having a swallowing disorder and receiving a mechanically altered diet while at the facility. The clinical record for Resident #57 documented an admission weight of 209 lbs (pounds) on 3/11/2021 and a weight of 195.0 lbs on 3/25/2021 for a 14 pound weight loss in 14 days. The clinical record further documented the most current weight of 176.4 lbs on 5/7/2021, for a 32.6 pound weight loss from 3/11/2021 to 5/7/2021. The physician orders for Resident #57 documented in part, - "Regular diet, Pureed texture, Nectar consistency. Order Date: 3/12/2021." - "Magic Cups (dietary supplement) two times a day with lunch and dinner daily. Order Date: 4/13/2021." - "Med Pass 2.0 (dietary supplement) three times a day 120ml (milliliter) TID (three times a day) for supplement. Order Date: 3/26/2021." The progress notes for Resident #57 documented in part, - "3/26/2021 10:05 (10:05 a.m.) Reviewed Clinical Indicator: Reviewed in RAR (resident at risk) for weight loss, down 14# (14 pounds) this week. Remains obese with BMI (body mass index) of 30.5 (4). Dysphagia (5), requires puree texture	F 657	The DON or designee will review resident with current significant weight changes to ensure the care plan has been revised appropriately. DON or designee will audit significant weight changes weekly for 4 weeks for orders, care plan revisions. Corrections will be made as identified. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the Quality Assurance Committee. Continued compliance will be monitored through the quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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with nectar thick liquids. ST (speech therapy) following for swallowing. PO (by mouth) intake is poor, <50% (less than fifty percent) most meals. Guest also on Lasix daily (diuretic medication). Action Taken: Will increase Med Pass supplement to TID, staff assist with meals as needed, encourage intake of meals and supplements. Response to Previous Actions Taken: Continue to monitor weekly weight trends."
- "4/13/2021 09:30 (9:30 a.m.) Reviewed Clinical Indicator: Reviewed in RAR d/t (due to) weight loss. Current weight 185#, down 23# since admission. BMI = 29 remains above IBW (ideal body weight). Diet: Puree with nectar liquids. Intake is variable, <75% (less than seventy-five percent) most meals. ST following for swallowing fxn (function). He receives Med Pass supplement TID. Action Taken: Will add Magic cup with lunch and dinner meals. Staff encourage intake of meals and supplements. Response to Previous Actions Taken: Continue to monitor weekly weights in RAR."

The nutritional evaluation for Resident #57 dated 3/15/2021 documented in part, "...Med Pass added daily d/t (due to) risk for weight loss. No pressure areas noted. Weekly weights will be monitored in RAR for at least 4 (four) weeks..."

The comprehensive care plan for Resident #57 dated "3/22/2021" documented in part, "[Resident #57] is at nutritional and/or dehydration... Date Initiated: 03/22/2021; Revision on: 03/22/2021." Under "Interventions" it documented in part, "...Follow in RAR (resident at risk) per protocol. Date Initiated: 03/22/2021" and "...Obtain weight at a minimum of monthly. Report significant weight changes of 5% x 1 month (five percent in

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one month), 7.5% x 3 months (seven and a half percent in three months) or 10% x 6 months (ten percent in six months) to the physician and dietician. Date Initiated: 3/22/2021. The care plan failed to evidence revision or documentation to address the resident's significant weight loss documented on 3/26/2021.

On 5/12/2021 at approximately 10:33 a.m., an interview was conducted with LPN (licensed practical nurse) #4, the unit manager. When asked the purpose of the comprehensive care plan, LPN #4 stated that it notified everyone what was going on with the resident at that time. LPN #4 stated that other staff were able to review the care plan to get an idea of the care that the resident required. LPN #4 stated that weekly RAR meetings were conducted on each unit to discuss any residents who had weight loss. LPN #4 stated that the dietician would request weekly weights to monitor residents and add supplements as needed. LPN #4 stated that when they had the RAR meetings to discuss residents with weight loss they also revised the care plan to include any interventions to address the significant weight loss.

On 5/12/2021 at approximately 11:15 a.m., a request was made to ASM #1 for the facility policy on developing and implementing the care plan.

The facility policy, "Interdisciplinary Care Plan" dated "06/17" documented in part, "...4. Care plans are revised as dictated by change(s) in the guest's condition. Reviews are done at least quarterly..."

On 5/10/21 at approximately 9:50 a.m., during survey entrance ASM #1, the administrator and

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ASM #2, the director of nursing stated that the facility used Lippincott as their standard of practice.

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." (6)

On 5/12/2021 at approximately 11:15 a.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of operations and ASM #5, the senior clinical transition specialist were made aware of the findings.

No further information was provided prior to exit.

Reference:

1. Encephalopathy: "Encephalopathy is a general term describing a disease that affects the function or structure of your brain." This information is taken from the website https://www.healthline.com/health/hepatic-encephalopathy.

2. Dementia: A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This

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F 657	Continued From page 66 information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm. 3. Osteoarthritis: Osteoarthritis occurs when cartilage, the tissue that cushions the ends of the bones within the joints, breaks down and wears away. This information was obtained from the website: https://www.nia.nih.gov/health/osteoarthritis 4. BMI is body mass index (BMI). This information was obtained from the website: https://medlineplus.gov/ency/article/007196.htm 5. Dysphagia: A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html. 6. Fundamentals of Nursing Lippincott Williams & Wilkins 2007, Lippincott Company Philadelphia pages 65-77.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and clinical record review, the facility staff failed to follow professional standards of practice for one of 32 residents in the survey sample, Resident #128.	F 658	Resident #128 orders for Tylenol were reviewed and revised based on pain level parameters. Residents with orders for pain medication have the potential to be affected.	6/15/21

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F 658	Continued From page 67 The facility staff failed to clarify two different dose orders for Tylenol which were both prescribed as needed for pain for Resident #128, to determine which and when each dose of the medication should be administered based on pain level parameters. The findings include: Resident #128 was admitted to the facility on 4/21/21 with diagnoses including, but not limited to, COPD (Chronic Obstructive Pulmonary Disease) (1) and heart failure. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 4/25/21, Resident #128 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). She was coded as experiencing occasional pain at a maximum level of eight out of ten during the look back period. On 5/11/21 at 11:34 a.m., Resident #128 was observed lying in bed. When asked if she experiences pain, she stated she does. She stated sometimes it is severe. When asked if the facility staff brings pain medications to her in a timely manner, Resident #128 stated, "Usually." When asked if the pain medications she receives are strong enough to allow her to manage the pain, Resident #128 stated, "Usually." A review of Resident #128's clinical record revealed the following physician's orders, both dated 4/22/21: - "Tylenol (2) Extra Strength Tablet 500 mg (milligrams). Acetaminophen. Give 1000 mg by	F 658	The DON or designee will provide education on pain medication that would include clarifying multiple PRN pain medication orders without pain level parameters. This will be part of chart review as well with clinical operations meetings. The DON or Designee will review resident charts for multiple pain PRN medications without parameters. Clarification of parameters will be obtained where necessary. DON or designee will audit residents with changes to pain and new admissions medication weekly for 4 weeks to ensure clarification was obtained on parameters where needed on pain medication. Corrections will be made as identified. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/designee to the Quality Assurance Committee. Continued compliance will be monitored through the quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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mouth every 8 hours as needed for pain."

- "Tylenol Tablet 325 mg (Acetaminophen) Give 2 tablets by mouth every 6 hours as needed for pain NTE (not to exceed) 3 G (grams)/24 HRS (hours)."

A review of Resident #128's TARs (treatment administration records) revealed she received a dose of 650 mg of Tylenol on 5/2/21, 5/9/21, and 5/10/21. She did not receive a dose of 1000 mg of Tylenol in May 2010.

A review of Resident #128's comprehensive care plan, dated 4/22/21 and updated 5/3/21, revealed, in part: [Resident #128] is at risk for pain/or has pain...Administer medications as ordered."

On 5/11/21 at 3:19 p.m., LPN (licensed practical nurse) #1 was shown the above two orders for Tylenol and asked how she would determine which order for Tylenol to administer to a resident. LPN #1 stated the orders were very similar. She stated she would check both orders to make sure they were still valid. She stated she would check to see if either order had been administered recently. LPN #1 stated, "[Order] clarification is always a plus." LPN #1 stated she would probably ask for clarification of this order before administering either order."

On 5/11/21 at 4:45 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing (DON), and ASM #3, the regional director of operations, were informed of these concerns.

On 5/12/21 at 10:34 a.m., LPN #4 was shown the above two orders for Tylenol. LPN #4 stated,

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"These should have been clarified." She stated a nurse would not know which order to give in which setting for a resident.

On 5/12/21 at 10:58 a.m., ASM #2 was interviewed. ASM #2 stated, "The manager clarified the order yesterday."

A review of the facility policy, "Medication Administration," contained no information related to clarification of orders.

On 05/10/2021 at approximately 9:50 a.m., during the entrance conference with ASM [administrative staff member] # 1, administrator and ASM # 2, director of nursing stated that the standard of practice the nursing staff follows was Lippincott."

According to "Lippincott Manual Of Nursing Practice", Eighth Edition: by Lippincott Williams & Wilkins, pg. 87 read: "Nursing Alert: Unusual dosages or unfamiliar drugs should always be confirmed with the health care provider and pharmacist before administration." On pg. 15, the following is documented in part, "Inappropriate Orders: 2. Although you cannot automatically follow an order you think is unsafe, you cannot just ignore a medical order, either. b. .. Call the attending physician, discuss your concerns with him, obtain appropriate..orders. c. Notify all involved medical and nursing personnel.... d. Document clearly."

No further information was provided prior to exit.

REFERENCES
(1) COPD is "a general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic

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F 658	Continued From page 70 bronchitis." Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) "Acetaminophen is used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body." This information is taken from the website https://medlineplus.gov/druginfo/meds/a681004.html.	F 658		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 686		6/15/21

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F 686	Continued From page 71 Based on observation, staff interview, facility document review, clinical record review, and facility policy review, it was determined the facility staff failed to provide wound care in a manner to promote healing and prevent infection of a pressure wound for two of 38 residents in the survey sample, Residents # 64 and # 18. 1. The facility staff failed to administer a wound treatment in a manner to promote healing and prevent infection for Resident #64. The facility staff failed to wash their hands before and after glove use and failed to wash their hands for a minimum of 15-20 seconds during Resident # 64's wound care. 2. The facility staff failed to administer a wound treatment in a manner to promote healing and prevent infection for Resident #18. LPN (licensed practical nurse) #4, failed to disinfect scissors removed from their uniform pocket before cutting dressings applied directly to Resident #18's wound, failed to wash their hands before and after glove use and failed to ensure handwashing for a minimum of 20 seconds during Resident # 18's wound care. The findings include: 1. Resident # 64 was admitted to the facility with diagnoses that included but were not limited to: heart disease, pressure ulcer and arthritis. Resident # 64's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 03/21/2021, coded Resident # 64 as scoring a 13 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 - being cognitively intact for making daily	F 686	Resident #64: The nurse that provide wound care was provided with 1:1 training on proper use of gloves during wound care and appropriate handwashing in general as well as with the use of gloves. No negative outcome occurred as a result of this practice. Resident #18: The nurse that provided wound care was provided 1:1 education on how to sanitize reusable medical equipment and appropriate handwashing in general as well as with the use of gloves. No negative outcome occurred as a result of this practice. Residents with pressure injuries have the potential to be affected. Licensed Nursing staff will complete education leaded into the electronic "Relias" learning system on Handwashing and Cleaning of Equipment an surfaces. Nursing administration will complete 5 wound treatment observations per week for 2 weeks than 3 wound treatment observations per week for 2 weeks. Corrections will be made as identified. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the Quality Assurance Committee. Continued compliance will be monitored through the quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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decisions. Section M "Skin Conditions)" coded Resident # 64 as having a pressure ulcer upon admission.

The facility's "Nursing Comprehensive Evaluation" for Resident # 64 dated 03/17/2021 documented in part, "Admission: 03/17/2021." Under section K. Skin" it documented, "Right Buttock. Stage 2 [1]."

The facility's "Braden Scale" [2] for Resident # 64 documented, "Effective Date: 03/17/2021. Score: 15. At Risk."

The comprehensive care plan for Resident # 64 dated 03/17/2021 documented in part, "Need. [Resident # 64] is at risk for impaired skin integrity/pressure ulcer. Admit to the facility with skin breakdown. Date Initiated: 03/17/2021." Under "Interventions" it documented in part, "Conduct weekly head to toe skin assessments, document and report abnormal findings to the physician. Date Initiated: 03/17/2021."

The most current physician's wound care order dated 05/02/2021 for Resident # 64 documented, "Wound Care: Sacral Wound - clean with NS - pack loosely with ¼ [one quarter] DAKINS [3] moistened gauze and PRN [as needed] - cover with dry dressing."

On 05/11/2021 at approximately 10:20 a.m., an observation was conducted of LPN [licensed practical nurse] # 4 conducting a dressing change on Resident # 64's sacrum [4]. Prior to the start of the wound care this surveyor introduced themselves to Resident # 64 and asked permission to have one of the female nurses of

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the survey team observe their wound care. Resident # 64 stated that it was ok with them that this surveyor conduct the observation because their doctor was a male. The wound care was observed by this surveyor in the presence of a female nurse of the survey team.

Resident # 64 was positioned on her left side with the assistance of CNA [certified nursing assistant] # 4 and a clean barrier sheet was set up over Resident # 64's over-the-bed-table after disinfecting it. LPN # 4 then placed the clean dressings and treatments on the over-the-bed-table. After donning a clean pair of gloves, LPN # 4 removed the old dressing, placed it in a trash bag, then removed their gloves, went to the sink and washed their hands. Observation revealed LPN #4's hand washing was completed in five seconds. LPN # 4 then put on a clean pair of gloves, cleaned the wound with normal saline, removed gloves, and immediately donned a clean pair of gloves without sanitizing or washing their hands. LPN #4 then applied the treatment and dressing, removed gloves, and donned a new pair of gloves without sanitizing or washing their hands. LPN # 4 then assisted CNA # 4 in repositioning and covering Resident # 64, removed gloves, went to the sink and washed their hands. The hand washing was observed to be completed in five seconds.

On 05/11/2021 at 11:35 a.m., an interview was conducted with LPN # 4. When asked to describe the procedure for hand washing LPN # 4 stated, "Turn on the water, wet hands, apply soap, suds hands and wash for 15 to 30 seconds, rinse hands, dry them with a paper towel then use it to turn the water off." When asked about the time frame of washing their hands, LPN # 4

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stated, "I'm not sure." When asked to describe the procedure for washing hands when changing gloves, LPN # 4 stated that hands should be washed or sanitized before donning gloves and after removing them. LPN #4 was informed of the above observations of hand washing during Resident # 64's wound care procedure. LPN # 4 stated that they didn't use proper hand hygiene when washing their hands and before donning gloves and after removing them. LPN # 4 further stated, "I rushed through it."

The facility's policy "Hand Washing" documented in part, "I. C. Wash well under running water for a minimum of 20 seconds, using a rotary motion and friction."

The facility's policy "Using Gloves" documented in part, "II. E. Perform hand hygiene after removing gloves."

On 05/11/2021 at approximately 4:45 a.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, and ASM # 3, regional director of operations, were made aware of the above findings.

No further information was provided prior to exit.

References:

[1]. Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis.Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result

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from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence-associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions. This information was obtained from: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/

[2] The Braden Scale is a standardized tool to assess pressure ulcer risk. This information was obtained from the website: https://pubmed.ncbi.nlm.nih.gov/28512923/

[3] Used to prevent and treat skin and tissue infections that could result from cuts, scrapes and pressure sores. It is also used before and after surgery to prevent surgical wound infections. Dakin's solution is a type of hypochlorite solution. It is made from bleach that has been diluted and treated to decrease irritation. Chlorine, the active ingredient in Dakin's solution, is a strong antiseptic that kills most forms of bacteria and viruses. This information was obtained from the website: https://www.webmd.com/drugs/2/drug-62261/dakins-solution/details.

[4] A shield-shaped bony structure that is located at the base of the lumbar vertebrae and that is connected to the pelvis. The sacrum forms the posterior pelvic wall and strengthens and stabilizes the pelvis. Joined at the very end of the sacrum are two to four tiny, partially fused vertebrae known as the coccyx or "tail bone". The coccyx provides slight support for the pelvic

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organs but actually is a bone of little use. This information was obtained from the website: https://medlineplus.gov/ency/imagepages/19464.htm

2. Resident # 18 was admitted to the facility with diagnoses that included but were not limited to: pressure ulcer and multiple sclerosis [1].

Resident # 18's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/12/2021, coded Resident # 18 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Section M "Skin Conditions)" coded Resident # 18 as having a pressure ulcer upon admission. Under "M0300" it documented, "Stage 3 - Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of the tissue loss. May include undermining and tunneling [3]."

The facility's "Nursing Comprehensive Evaluation" for Resident # 18 dated 07/17/2019 documented in part, "Admission: 07/17/2019." Under section K. Skin" it documented, "Right Buttock. Stage 2. Left Buttock. Stage 2."

The facility's "Braden Scale" for Resident # 18 documented, "Effective Date: 03/17/2021. Score: 16. At Risk."

The comprehensive care plan for Resident # 18 with a revision date of 11/13/2020 documented in part, "Need. [Resident # 18] has actual

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impairment to skin integrity r/t [related to] sage 3 to sacrum. Date Initiated: 07/17/2019. Revision on: 11/13/2020." Under "Interventions" it documented, "Observe location, size and treatment of skin injury. Report abnormalities, failure to heal, s/s [signs/symptoms] of infection, maceration, etc. to physician. Date Initiated: 07/17/2019."

The current physician's wound care order dated 03/05/2021 for Resident # 18 documented, "cleanse sacral wound with NS apply hydrofera [2] blue dressing then dry dressing everyday."

On 05/11/2021 at approximately 10:35 a.m., an observation was conducted of LPN [licensed practical nurse] # 4 conducting a dressing change on Resident # 18's sacrum. Prior to the start of the wound care this surveyor introduced themselves to Resident # 18 and asked permission to have one of the female nurses of the survey team observe their wound care. Resident # 18 stated that it was ok with them that this surveyor conduct the observation because their doctor was a male. The wound care was observed by this surveyor in the presence of a female nurse of the survey team.

Resident # 18 was positioned on her left side with the assistance of CNA [certified nursing assistant] # 4 and a clean barrier sheet was set up over Resident # 18's over-the-bed-table after disinfecting it. LPN # 4 then placed the clean dressings and treatments on the over-the-bed-table. LPN # 4 reached into her lab coat and took out a pair of scissors and placed them on the over-the-bed-table without disinfecting the scissors. After donning a clean pair of gloves, LPN # 4 removed the old dressing,

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placed it in a trash bag and removed their gloves, went to the sink and washed their hands. Observation revealed LPN #4 completed handwashing in five seconds. LPN # 4 then put on a clean pair of gloves, cleaned the wound with normal saline, removed gloves, and immediately donned a clean pair of gloves without sanitizing or washing their hands. LPN # 4 then asked CNA # 4 to retrieve a bottle of peri wash. CNA # 4 removed their gloves, placed them in the trash bag, opened the door to the resident's room without washing their hands, and left the room. CNA # 4 then returned to the room with the bottle of peri wash and donned a clean pair of gloves. LPN #4 used the bottle of peri wash obtained by CNA #4, who was not observed washing their hands, and completed the procedure. LPN #4 then applied the treatment to the wound wearing the same gloves worn when handling the peri wash. LPN # 4 used the scissors they removed from their pocket, to cut the dressing to size without disinfecting them, and applied the dressing to Resident #18's sacral wound. LPN #4 then removed gloves, donned a new pair of gloves without sanitizing or washing their hands. LPN # 4 then assisted CNA # 4 in repositioning and covering Resident # 18, removed gloves, went to the sink and washed their hands. The hand washing was observed to be completed in five seconds.

On 05/11/2021 at 11:30 a.m., an interview was conducted with CNA # 4. When asked to describe the procedure for hand washing, CNA # 4 stated, "Turn on the water, wet hands, apply soap, rub hands together, wash the backs of your hands and between the fingers, rinse hands, dry them with a paper towel then use it to turn the water off." When asked to describe the

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procedure for washing hands when changing gloves, CNA # 4 stated that hands should be washed or sanitized before donning gloves and after removing them. CNA #4 was informed of the above observations of them removing their gloves and leaving the resident's room without washing their hands to retrieve perri wash used during the wound care by LPN #4. CNA # 4 stated that they should have washed or sanitized their hands after removing the gloves before leaving the room.

On 05/11/2021 at 11:35 a.m., an interview was conducted with LPN # 4. When asked to describe the procedure for hand washing, LPN # 4 stated, "Turn on the water, wet hands, apply soap, suds hands and wash for 15 to 30 seconds, rinse hands, dry them with a paper towel then use it to turn the water off." When asked about the time frame of washing their hands, LPN # 4 stated, "I'm not sure." When asked to describe the procedure for washing hands when changing gloves, LPN # 4 stated that hands should be washed or sanitized before donning gloves and after removing them. LPN #4 was informed of the above observations of hand washing during Resident # 18's wound care procedure. LPN # 4 stated that they didn't use proper hand hygiene when washing their hands and before donning gloves and after removing them. LPN # 4 further stated, "I rushed through it." When asked if they disinfected the scissors used before cutting the dressing applied to Resident #18's wound, LPN # 4 stated that they disinfected them before placing them in their pocket. When asked if the scissor were still disinfected after having them in their pocket, LPN # 4 stated, "I should have cleaned them when I took them out of my pocket."

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On 05/10/2021 at approximately 9:50 a.m., during the entrance conference with ASM [administrative staff member] # 1, administrator and ASM # 2, director of nursing stated that the standard of practice the nursing staff follows was Lippincott."

"Disinfection, noncritical patient care equipment. Introduction ...reusable noncritical patient care equipment should be disinfected after use, before use on another patient." Lippincott Procedures - Disinfection, noncritical patient care equipment. Revised: November 20, 2020.

"In a study conducted by the International Conference on Nosocomial and Healthcare related Infections in Atlanta Georgia, March 2000 showed that ordinary items can make your patients sick. In one study, a researcher gathered scissors that nurses and physicians kept in their pockets, as well as communal scissors left on dressing carts and tables. Three-quarters of the scissors carried microorganisms, including Staphylococcus aureus, Groups A and B streptococcus, and gram-negative bacilli. The solution is quite simple. If health care workers swab the scissors with alcohol after each use, they will virtually eliminate the risk of transmission of microorganisms. In the study, contaminated scissors were effectively disinfected after swabbing the scissors with alcohol." Reference: Embil JM, Dyck B, McLeod J, et al. Scissors as a potential source of nosocomial infection? Presented at the 4th Decennial International Conference on Nosocomial and Healthcare-Associated Infections. Atlanta; March 8, 2000.

On 05/11/2021 at approximately 4:45 a.m., ASM [administrative staff member] # 1, administrator,

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F 686	Continued From page 81 ASM # 2, director of nursing, and ASM # 3, regional director of operations, were made aware of the above findings. No further information was provided prior to exit. [1] A nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. This information was obtained from the website: https://medlineplus.gov/multiplesclerosis.html. [2] Hydrofera Blue is a type of wound dressing. This information was obtained from the website: https://hydrofera.com/hydrofera-blue/	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an	F 690		6/15/21

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F 690	Continued From page 82 indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, it was determined that facility staff failed to provide appropriate treatment and services for the care of a Foley catheter to prevent infection for one of 38 residents in the survey sample, Residents # 18. Separate observations revealed Resident #18's Foley catheter tubing directly on the floor. The findings include: Resident # 18 was admitted to the facility with diagnoses that included but were not limited to: neuromuscular dysfunction of the bladder [1] and multiple sclerosis [2]. Resident # 18's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/12/2021, coded Resident # 18 as scoring a 15 on the brief interview for mental	F 690	Resident #18's tubing was changed to leg bag drainage while up in the wheelchair. There was no negative outcome to this resident as a result of this practice. Residents with indwelling Foley catheters are potentially at risk. All current residents with Foley catheters will be observed for positioning of tubing to prevent dragging or backflow. Identified issues will be corrected. Appropriate adjustments will be made to orders and care plans for the use of leg bags when up in wheelchair (unless refused by resident and this would be care planned as well). DON or designee will provide nursing staff education on proper care of Foley tubing	

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F 690	Continued From page 83 status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 18 was coded as requiring extensive assistance of one staff member for activities of daily living. Section H "Bladder and Bowel" coded Resident # 18 as having an indwelling catheter. On 05/10/21 at 3:14 p.m., an observation of Resident # 18 revealed the resident sitting in their room in a wheelchair. Further observation revealed the tubing of the resident's catheter under the wheelchair resting directly on the floor. On 05/11/21 at 1:04 p.m., an observation of Resident # 18 revealed the resident sitting in a wheelchair in their room. Further observation revealed the tubing of the resident's catheter under the wheelchair resting directly on the floor. On 05/11/21 at 3:43 p.m., an observation of Resident # 18 was conducted with LPN [licensed practical nurse] # 4, unit manager. Resident # 18 was observed in their room sitting in a wheelchair. Observation of the catheter tubing revealed it was under the wheelchair resting on the floor. LPN # 4 stated that the tubing should not be on the floor and that it was an infection control concern. The POS [physician's order sheet] for Resident # 18 dated 05/2021 documented in part, "Foley Catheter care every shift for neurogenic bladder. Start Date: 07/02/2020." The comprehensive care plan for Resident # 18 dated 07/09/2020 documented in part, "Need: [Resident # 18] is at risk for urinary tract infection and catheter related trauma: has indwelling catheter r/t [related to] Neurogenic bladder, Date	F 690	to prevent infection which will include tubing and bag placement to prevent dragging or placement to prevent backflow. Nursing administration will complete auditing 3 times a week for 2 weeks and then 2 times a week for 2 weeks of Foley tubing and bag placement. Corrections will be made as identified. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/designee to the Quality Assurance Committee. Continued compliance will be monitored through the quality assurance program. Additional education and monitoring will be initiated for an identified concerns.	

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Initiated: 07/09/2020." Under "Interventions" it documented in part, "Position catheter bag and tubing below the level of the bladder. Check tubing for kinks each shift. Date Initiated: 07/09/2020."

On 05/10/2021 at approximately 9:50 a.m., during the entrance conference with ASM [administrative staff member] # 1, administrator and ASM # 2, director of nursing stated that the standard of practice the nursing staff follows was Lippincott."

According to Fundamentals of Nursing Lippincott Williams and Wilkins Eighth Edition 2006, Lippincott Company, page 757, titled Renal and Urinary Disorders, under the heading "Management of a Patient with an Indwelling Catheter and Closed Drainage System" the subheading: "Maintaining a closed drainage system: 2. Maintain an unobstructed urine flow. b. Urine should not be allowed to collect in tubing because free flow of urine must be maintained to prevent urinary tract infection. Improper drainage occurs when the tubing is kinked or twisted, allowing pools of urine to collect in the tubing. c. Keep the bag off the floor to prevent bacterial contamination."

On 05/11/2021 at approximately 4:45 a.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, and ASM # 3, regional director of operations, were made aware of the above findings.

No further information was provided prior to exit.

References:
[1] A problem in which a person lacks bladder control due to a brain, spinal cord, or nerve

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F 690	Continued From page 85 condition. This information was obtained from the website: https://medlineplus.gov/ency/article/000754.htm. [2] A nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. This information was obtained from the website: https://medlineplus.gov/multiplesclerosis.html.	F 690		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced	F 693		6/15/21

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F 693	Continued From page 86 by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to ensure the appropriate treatment and services to prevent complications of enteral feeding per the physicians orders for one of 38 residents in the survey sample, Resident #115. The facility staff failed to administer water flushes, and failed to record the total intake for the resident daily, per the physician's order. The findings include: Resident #115 was admitted to the facility on 4/9/21 with diagnoses including Parkinson's disease (1), dementia (2), and history of a stroke requiring the placement of a feeding tube (3). On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 4/13/21, Resident #115 was coded as being severely cognitively impaired for making daily decisions, having scored three out of 15 on the BIMS (brief interview for mental status). She was coded as receiving greater than 51% of her total calories through a feeding tube. On the following dates and times, 5/11/21 at 9:58 a.m., 12:26 p.m., and 3:00 p.m., Resident #115 was observed lying in bed with the head her bed elevated. A tube feeding solution bag and a bag of water were hanging on a pole. Both feeding solution and the water were threaded through an automatic pump. The pump settings were 60 mls/hour (milliliters per hour) continuous for the tube feeding solution, and 40 mls of water one time flush each hour.	F 693	Resident #115: the tube feeding and water flushes were adjusted per order. The nurse that did not understand the orders received 1:1 education that included documentation of intake. Residents who are tube fed are potentially at risk. Residents who are tube fed will have their orders and Medication Administration Record reviewed to ensure orders for feeding and water are set appropriately and that intake amount is recorded each shift or as ordered. DON or designee will in-service licensed nursing staff on tube feeding pump settings to include clearing the pump each shift and verifying settings at the beginning of shift. Nursing administration will round on residents receiving tube feeding 5 times per week for 4 weeks to ensure appropriate use of feeding pump and documentation of amount of tube feeding is administered. Corrections will be made as identified. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the Quality Assurance Committee. Continued compliance will be monitored through the quality assurance program. Additional education and monitoring will be initiated for any additional concerns.	

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A review of Resident #115's clinical record revealed the following physician's orders, dated 4/21/21: "Jevity 1.2 (tube feeding solution) @ (at) 60 ml per hour...Jevity 1.2 at 60 ml per hour. Total amount taken in every night shift." The clinical record also contained the following physician's order: "Enteral (tube feeding) Feed Order Four times a day for Maintenance Flush PEG tube with 120 cc (cubic centimeters) of water."

A review of Resident #115's MARs (medication administration records) and TARs (treatment administration records) revealed staff signatures for all dates in May 2021 for these orders, indicating the feedings and water were administered per the order. However, none of the night shift records contained a total amount of tube feeding solution taken in by the resident.

A review of Resident #115's comprehensive care plan, dated 4/14/21 and revised 4/19/21, revealed, in part: "[Resident #115] is unable to tolerate nutritionally adequate food and/or fluids by mouth requiring the use of a feeding tube...Administer tube feeding as ordered."

On 5/11/21 at 3:00 p.m., LPN (licensed practical nurse) #6 was accompanied to Resident #115's room and the residents the feeding tube pump settings were observed. When asked to describe the settings, LPN #6 stated it was set to deliver 60 mls of Jevity each hour to the resident via the resident's feeding tube. She stated it was set to deliver a once-an-hour flush of 40 mls of water. When asked if she knew if these settings matched the physician's order, LPN #6 stated she thought so, but would need to verify. LPN #6 checked Resident #115's physician's orders, and stated, "I can't tell." She stated she thought that

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when the pump was programmed for the tube feeding solution, the pump automatically provided the 40 mls of water flush each shift. LPN #6 stated, "No - the orders don't match what the pump is doing." She stated she did not know how to prevent the pump from delivering the 40 mls of water flush each hour.

On 5/11/21 at 4:45 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing (DON), and ASM #3, the regional director of operations, were informed of these concerns.

On 5/12/21 at 10:34 a.m., LPN #4, a unit manager, was interviewed. She stated she was very familiar with the programming and operations of the feeding tube pumps. She stated the pumps are programmed according to the physician's orders. She stated the pump requires a nurse to program both the tube feeding solution amount and rate as well as the water flush amount and rate. LPN #4 stated the pumps automatically deliver the amount that a nurse has programmed. She stated the tube feeding pumps do not have an intrinsic automatic setting for water flushes of any kind. LPN #4 stated, "We always have to set the tube feeding and water amounts manually." She stated the tube feeding and flush amounts vary for each resident, and are adjusted as the resident's needs or conditions change. When asked to review Resident #115's TARs for the total amount of intake each night shift, LPN #4 stated, "They are missing a prompt. There should be an amount each shift. You can't just sign it off."

On 5/12/21 at 10:58 a.m., ASM #2 was interviewed. She verified that the tube feeding

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pumps must be manually programmed for both the tube feeding and the water amounts and rates, and that Resident #115's pump had been incorrectly programmed. ASM #2 stated the night shift staff should have been recording the total amount of tube feeding and water taken in by the resident for each preceding 24 hour period.

A review of the tube feeding pump instructions revealed steps to be followed to manually program the pump for both the tube feeding solution and the water flushes. The instructions contained no information about the pump automatically being set to deliver water flushes prior to a nurse programming it to do so.

A review of the facility policy, "Enteral Nutrition," revealed, in part: "The nurse obtains an order for placement of an enteral feeding tube. Order should include the following information: the formula to be used...The rate and/or timing of administration...Total volume to be given per 24-hour period...Method of administration...Volume of water given as water flush...Once the tube has been placed and tube placement confirmed, the nurse administers the enteral feeding regimen according to formula, system type, and method of delivery ordered by the physician...The nurse irrigates the feeding tube with the prescribed amount of water and frequency to maintain or restore patency of the feeding tube and to provide free water."

No further information was provided prior to exit.

REFERENCES
(1) "Parkinson's disease (PD) is a type of movement disorder. It happens when nerve cells in the brain don't produce enough of a brain

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F 693	Continued From page 90 chemical called dopamine. Sometimes it is genetic, but most cases do not seem to run in families." This information is taken from the website https://medlineplus.gov/parkinsonsdisease.html. (2) "Dementia is a gradual and permanent loss of brain function. This occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior." This information is taken from the website https://medlineplus.gov/ency/article/000746.htm. (3) "A PEG (percutaneous endoscopic gastrostomy) feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach. PEG feeding tube insertion is done in part using a procedure called endoscopy. Feeding tubes are needed when you are unable to eat or drink. This may be due to stroke or other brain injury, problems with the esophagus, surgery of the head and neck, or other conditions." This information is taken from the website https://medlineplus.gov/ency/patientinstructions/000900.htm	F 693		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences,	F 695		6/15/21

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F 695	Continued From page 91 and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, it was determined that facility staff failed to provide respiratory services according to the physician's orders and professional standards for seven of 38 residents in the survey sample, Residents #15, #58, #128, #337, #71, #333 and #6. The facility staff failed to administer oxygen at the oxygen flow rate according to the physician's orders for Resident # 15, Resident #58 and Resident #337. For Resident #128, the facility staff, the facility failed to obtain an order for oxygen and the used of a CPAP (continuous positive airway pressure) machine prior to survey team entrance on 5/10/21. The facility staff failed to change the oxygen tubing between 4/21/21 and 5/11/21. The facility staff failed to ensure an order for the use of oxygen was written following an emergent event and obtaining the verbal order from the physician, for Resident #6 on 4/16/21 and Resident #333 on 3/9/21. The facility staff failed to provide tracheostomy [trach] care in a safe manner for Resident #6. During Resident #6's trach care on 5/11/21 at 8:20 AM there was no ambu bag (4) in his room. The findings include: 1. Resident # 15 was admitted to the facility with diagnoses that include but are not limited to:	F 695	Resident #15: Oxygen orders have been reviewed and revised and oxygen setting was set to the ordered rate of flow. No negative outcome occurred from either practice. Resident #58: Oxygen orders have been reviewed and revised and oxygen setting was set to ordered rate. No negative outcome occurred from either practice. Resident #337: Oxygen orders have been reviewed an revised and oxygen setting was set to ordered rate of flow. No negative outcome occurred from either practice. Resident #71: O2 was provided to resident upon discharge with verbal order (not written). Upon return of resident to the facility resident's orders were reviewed and resident did not require an oxygen order. No negative outcome occurred from this practice. Resident #128: Physicians orders for Oxygen and CPAP machine have been clarified and written and the tubing was changed and dated 5/10/21. No negative outcome occurred from this practice. Resident #6 and Resident #333: the nurse responsible for emergent transfer for these resident have received 1:1 counseling on writing the physician order for Oxygen after the verbal order is given.	

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F 695	Continued From page 92 congestive heart failure. Resident # 15's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 02/05/2021, coded Resident # 15 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded Resident # 15 for "Oxygen Therapy" while a resident. On 05/10/21 at 11:02 a.m., and at 1:58 p.m., observation of Resident # 15 revealed the resident in their room sitting in a wheelchair and receiving oxygen by nasal cannula from an oxygen concentrator. Observation of the flow meter on the oxygen concentrator revealed that Resident # 15 was receiving oxygen at two-and-a-half liters per minute. On 05/11/21 at 7:58 a.m., an observation of Resident # 15 revealed the resident lying in bed and receiving oxygen by nasal cannula from an oxygen concentrator. Observation of the flow meter on the oxygen concentrator revealed that Resident # 15 was receiving oxygen at two-and-a-half liters per minute. The physician's order dated 02/01/2021 for Resident # 15 documented, "Oxygen 2l/m [two liters per minute] via [by] nasal cannula [1] as needed for SOB [shortness of breath]." The comprehensive care plan for Resident # 15 with a revision date of 02/01/2021 failed to evidence documentation for the use of oxygen. On 05/11/21 at 2:11 p.m., an interview was conducted with LPN [licensed practical nurse] #	F 695	No negative outcome related to this practice. Resident #6: An Ambu bag was placed at bedside. No negative outcome related to this practice. Residents with Oxygen administration, CPAP use, resident with emergent hospital transfers and residents with tracheostomy are potentially at risk. DON or designee will audit 1. Current residents on O2 and their settings, 2. Current residents with CPAP orders; cleaning and changing of tubes 3. Residents with emergent transfers to hospital in the last 30 days for O2 order if used, and availability of emergency equipment at bedside for tracheostomy residents. DON or designee with educate the licensed nursing staff on checking oxygen settings with the physician orders, checking and clarifying CPAP orders: cleaning and changing of tube, order documentation of critical use of Oxygen and emergency equipment at bedside for tracheotomy residents. Nursing administration will monitor 1. oxygen settings weekly for 4 weeks 2. CPAP settings and equipment change dating weekly for 4 weeks, 3. Non-pharmacological interventions will be reviewed weekly for 4 weeks, 4. availability of emergency equipment for tracheostomy patients weekly for 4	

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F 695	Continued From page 93 4, unit manager. When asked to describe how to read the flow meter on an oxygen concentrator to determine the amount of oxygen being delivered to a resident, LPN # 4 stated, "The liter line should pass through the middle of the ball [float ball]." At 2:20 p.m., LPN # 4 was accompanied to Resident #115's room and was asked to read the oxygen flow rate on Resident # 15's oxygen concentrator. After entering Resident # 15 room and reading the flow meter LPN # 4 stated, "It's at two-and-a-half liters." When asked what the physician ordered the oxygen flow rate to be set at LPN # 4 referred to the physician's orders and stated that it should set at two liters per minute. The "Operating Instructions" provided by the facility for the oxygen concentrators documented in part, "Note: To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the flow knob until the ball rises to the line. Now, center the ball on the L/min line prescribed." On 05/11/2021 at approximately 4:45 a.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, and ASM # 3, regional director of operations, were made aware of the above findings. No further information was provided prior to exit. References: [1] Tubing used to deliver oxygen at levels from 1 to 6 L/min. The nasal prongs of the cannula extend approx. 1 cm into each naris and are connected to a common tube, which is then connected to the oxygen source. This information was obtained from the website: http://medical-dictionary.thefreedictionary.com/na	F 695	weeks. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/designee to the Quality Assurance Committee. Continued compliance will be monitored through the quality assurance program. Additonal education and oni	

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sal+cannula.

2. Resident # 58 was admitted to the facility on 12/13/2019 with diagnoses that included but were not limited to: acute and chronic respiratory failure [1] and chronic obstructive pulmonary disease [2]. Resident # 58's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 03/16/2021, coded Resident # 58 as scoring an 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 - being cognitively intact for making daily decisions. Under section "O0100 Special Treatments, Procedures and Programs" it documented in part, "C. Oxygen therapy. 2. While a Resident." Further review of this section revealed the box under "2. While a Resident", was not checked.

On 05/10/21 at 1:46 p.m., 05/11/21 at 7:57 a.m., and at 2:17 p.m., observation of Resident # 58 revealed the resident lying in bed and receiving oxygen by nasal cannula from an oxygen concentrator. Observation of the flow meter on the oxygen concentrator revealed that Resident # 58 was receiving oxygen at three liters per minute.

The POS [physician's order sheet' dated May 2021 for Resident # 58 documented, "O2 [oxygen] 4L [four liters] via [by] NC [nasal cannula] continuously. Start Date: 12/16/2019."

The comprehensive care plan for Resident # 58 dated 12/24/2019 documented in part, "Need: [Resident # 58] has a potential for difficulty breathing and risk for respiratory complications R/T [related to]: Chronic Obstructive Pulmonary

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Disease, COPD, Requires the use of: O2 @ [at] 4 liters. Date Initiated: 12/24/2019." Under "Intervention" it documented in part, "Administer medication & [and] treatments per physician's orders. Monitor for ineffectiveness, side effects and adverse reactions, report abnormal finds to the physician. Guest to use Oxygen via nasal cannula. Date Initiated: 12/24/2019."

On 05/11/21 at 2:11 p.m., an interview was conducted with LPN [licensed practical nurse] # 4, unit manager. When asked to describe how to read the flow meter on an oxygen concentrator to determine the amount of oxygen being delivered to a resident, LPN # 4 stated, "The liter line should pass through the middle of the ball [float ball]." At 2:17 p.m., LPN # 4 was accompanied to Resident #58's room and was asked to read the oxygen flow rate on Resident # 58's oxygen concentrator. After entering Resident # 58's room and reading the flow meter LPN # 4 stated, "It's at three liters." When asked what the physician ordered the oxygen flow rate to be set at LPN # 4 referred to the physician's orders and stated that it should set at four liters per minute.

On 05/11/2021 at approximately 4:45 a.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, and ASM # 3, regional director of operations, were made aware of the above findings.

No further information was provided prior to exit.

References:
[1] When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfa

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ilure.html.

[2] Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

3. Resident #128 was admitted to the facility on 4/21/21 with diagnoses including, but not limited to, COPD (Chronic Obstructive Pulmonary Disease) (2) and heart failure. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 4/25/21, Resident #128 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). She was coded as receiving oxygen both before and while a resident at the facility.

On 5/10/21 at 12:20 p.m., Resident #128 was observed sitting up in bed. She was receiving oxygen from a concentrator through a nasal cannula. The oxygen rate was set at 2 lpm (liters per minute). The oxygen tubing running from the concentrator to the resident did not have a date. When asked about the tubing, Resident #128 stated the tubing had not been changed since she had been admitted to the facility.

On 5/10/21 at 4:00 p.m., Resident #128 was observed sitting up in bed. She was receiving oxygen from a concentrator through a nasal cannula. The oxygen rate was set at 2 lpm (liters per minute).

On 5/11/21 at 9:18 a.m., Resident #128 was again asked about her oxygen tubing. She stated the tubing had still not been changed. At this

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time, LPN (licensed practical nurse) #12 entered the room. LPN #12 was asked to identify the date the oxygen tubing had been changed. LPN #12 stated, "There is no date on the tubing." She stated since there was no date, she could not say when or if the tubing had been changed. Resident #128 stated, "The tubing hasn't been changed since I was admitted, and [the tubing] is hard." LPN #12 stated the tubing should be changed weekly, and it is usually changed on the weekends.

On 5/11/21 at 11:34 a.m., Resident #128 was observed lying in bed. She was wearing a CPAP device. She removed the device, replaced the nasal cannula so she could receive oxygen, and participated in an interview. She stated she has been receiving oxygen since before she was admitted to the facility, and has been receiving it ever since her admission to the facility. Resident #128 further stated she uses the CPAP "all the time," including daytime naps as well as overnight sleep. When asked if the staff was providing any supervision or cleaning for the CPAP, she stated they were not.

Review of Resident #128's clinical record revealed an admission nursing assessment dated 4/21/21. The assessment documented: "Have you been told by a doctor that you have sleep apnea? Yes. Do you use a...CPAP? Yes. Do you use your machine regularly? Yes...Oxygen therapy? Yes. Oxygen therapy liter/min (liters per minute) and frequency? 2L (2 liters per minute)."

Review of Resident #128's clinical record revealed no physician's order for oxygen prior to 5/10/21, and no order at all for the use of a CPAP. The review revealed the following order for

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oxygen, dated 5/10/21 at 11:00 p.m.: "Continuous oxygen @ (at) 2 liters every shift for sob (shortness of breath)."

A review of Resident #128's comprehensive care plan dated 4/22/21, revealed, in part: "[Resident #128] has a potential for difficulty breathing and risk for respiratory complications...Administer medications and treatments per physician orders...Oxygen, CPAP..."

On 5/11/21 at 3:10 p.m., LPN #6 was asked to verify Resident #128's oxygen rate set on the concentrator with her physician's order for oxygen. LPN #6 stated the rate matched the order. When asked when the oxygen order had been initially written, LPN #6 stated, "It looks like it was just written this morning." When asked if Resident #128 had been receiving oxygen prior to the morning of 5/11/21, LPN #6 stated, "Yes. She has had it the whole time." When asked if she could locate an order for oxygen for Resident #128 prior to 5/10/21, she stated she could not. When asked to locate the orders for Resident #128's CPAP, LPN #6 looked and stated, "An order for that does not pop up." When asked if a resident needed an order for a CPAP, she stated yes. When asked how often CPAP equipment needs cleaning, LPN #6 stated she was not sure. LPN #6 stated, "Not every night, I don't think. Maybe every shift. I just really don't know."

On 5/11/21 at 3:19 p.m., LPN #1 was interviewed. When asked if an order is required for a resident to receive oxygen and for the use of a CPAP, she stated yes. She stated because oxygen is a medication, it requires an order. She stated the oxygen tubing is supposed to be changed weekly, and should be labeled with the date and the

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initials of the staff member who changed it. She stated the CPAP order should include the time of use, the rate, and any other maintenance or cleaning needs. When asked if she knew how often CPAP equipment should be cleaned, LPN #1 stated, "I feel like it is every month or so."

On 5/11/21 at 4:45 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing (DON), and ASM #3, the regional director of operations, were informed of these concerns.

On 5/12/21 at 10:34 a.m., LPN #4, a unit manager, was interviewed. When asked how a resident's oxygen rate is determined, LPN #4 stated, "I will talk to the resident, then look through the orders." She stated an order from a physician, which includes the rate and method of delivery, is required to administer oxygen. She stated an order is also needed for a resident's CPAP usage. She stated it is her practice to clean the CPAP mask with soap and water every day.

On 5/12/21 at 10:58 a.m., ASM #2 was interviewed. She stated an order is required to administer oxygen to a resident. ASM #2 stated an order is also required for a resident's CPAP usage. She stated the order should specify the settings on the machine.

A review of the facility policy, "Use of Oxygen," revealed, in part: "The O2 (oxygen) cannula or mask should be changed weekly and dated. It should be changed when soiled or dry."

A review of the facility policy, "Continuous Positive Airway Pressure (CPAP) Use," revealed, in part: "Cleaning of non-invasive respiratory equipment:

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Wash tubing and mask weekly with soap and water, rinse and let air dry...Verify the practitioner's order..."

No further information was provided prior to exit.

REFERENCES
(1) "CPAP (Continuous Positive Airway Pressure) is a treatment that uses mild air pressure to keep your breathing airways open...It involves using a CPAP machine that includes a mask or other device that fits over your nose or your nose and mouth, straps to position the mask, a tube that connects the mask to the machine's motor, and a motor that blows air into the tube. CPAP is used to treat sleep-related breathing disorders including sleep apnea." This information is taken from the website https://www.nhlbi.nih.gov/health-topics/cpap.

(2) COPD is "a general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis." Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.

4. Resident #337 was admitted to the facility on 4/26/21 with diagnoses including COPD (1) and lung cancer. She had not been a resident of the facility long enough to have a completed MDS (minimum data set) assessment. On the resident's admission nursing assessment dated 4/26/21, she was coded as being oriented to person, place, and time, and as receiving oxygen at the rate of two liters per minute.

On 5/11/21 at 9:53 a.m., Resident #337 was

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observed sitting up in bed. Her eyes were closed. Oxygen was being delivered to her from a concentrator through a nasal cannula. The middle of the ball on the concentrator flowmeter was observed between 3.5 and 4 liters per minute. During the observation, Resident #337 awoke and participated in an interview. Resident #337 stated her oxygen rate should be four liters per minute, and that is the rate her doctor had ordered for her both at home, and after she was admitted to the facility. She stated she had been receiving oxygen at 4 liters per minute ever since she was admitted. She stated she did not adjust the oxygen concentrator herself, and that a staff member had mentioned that the knob on the oxygen concentrator for adjusting the flow rate was broken.

On 5/11/21 at 12:15 p.m., Resident #337 was observed sitting in a wheelchair eating lunch. Oxygen was being delivered to her from a concentrator through a nasal cannula. The middle of the ball on the concentrator was observed between 3.5 and 4 liters per minute.

On 5/11/21 at 2:50 p.m., Resident #337 was observed sitting in a wheelchair in her room. LPN #12 came into the room. When asked to state the rate of Resident #337's oxygen, LPN #12 stated, "Well, the top of the ball is on 4. The bottom of the ball is on 3.5. There is no knob to adjust it." LPN #12 manipulated the knobs on the oxygen concentrator, and finally stated, "I fixed it. I moved it to 4. The line should go through the middle of the ball."

A review of Resident #337's clinical record revealed the following oxygen orders:

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- "4/27/21 Oxygen cont. (continuous) 2LPM (two liters per minute) via NC (nasal cannula) to keep sats (saturations) >92% (greater than 92%) every shift." This order was discontinued by LPN #12 at 3:00 p.m. on 5/11/21.

- "5/11/21 (at 3:00 p.m.) Oxygen cont. at 4 LPM via NC to keep sats >92% every shift." This order was entered by LPN #12.

A review of Resident #337's initial care plan dated 4/26/21, revealed, in part: "[Resident #337] has a potential for difficulty breathing and risk for respiratory complications...Administer medications and treatments per physician orders...Oxygen."

On 5/11/21 at 3:19 p.m., LPN #1 was interviewed. When asked if an order is required for a resident to receive oxygen, she stated yes. She stated because oxygen is a medication, it requires an order.

On 5/11/21 at 4:45 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing (DON), and ASM #3, the regional director of operations, were informed of these concerns.

On 5/12/21 at 10:34 a.m., LPN #4, a unit manager, was interviewed. When asked how a resident's oxygen rate is determined, LPN #4 stated, "I will talk to the resident, then look through the orders." She stated an order from a physician, which includes the rate and method of delivery, is required to administer oxygen.

On 5/12/21 at 10:58 a.m., ASM #2 was interviewed. She stated an order is required to

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administer oxygen to a resident.

No further information was provided prior to exit.

REFERENCES
(1) COPD is "a general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis." Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.

5. Resident #71 was admitted to the facility on 3/20/21 and readmitted on 4/23/21 with the diagnoses of but not limited to acute respiratory failure, gastrostomy, below knee amputation (right), end stage renal disease, chronic obstructive pulmonary disease, deep vein thrombosis, dialysis, chronic kidney disease, dysphagia, aphasia, diabetes, depression, dementia, osteomyelitis, and COVID-19. The 5-day MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 4/28/21 coded the resident as severely cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for bathing and toileting; extensive assistance for transfers, dressing, eating, and hygiene; and was incontinent of bowel and bladder.

A review of the clinical record revealed a nurse's note dated 4/16/21 at 3:32 PM documented, "resident tolerated her medications this morning; about 15 minutes later, CNA (Certified Nursing Assistant) notified nurse that resident was c/o (complaining of) trouble breathing; brought resident her inhaler and it helped for a few minutes; CNA put pulse ox (oxygen) on resident

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on monitored, she notified nurse that resident's PO2 (pulse oxygen saturation) went down to 86%; put resident on 2lpm (two liters per minute) of O2 (oxygen); MD (medical doctor) was called and notified, MD said to send resident out to hospital; notified niece, (name) also 146/62 96.8 79 16 86%y (Blood pressure 146/62, temperature 96.8, pulse 79, respirations 16, and oxygen saturation 86%)."

A review of the physician's orders failed to reveal any evidence that there was an order to administer the oxygen that was documented in the above note.

On 5/12/21 at 8:37 AM an interview was conducted with RN #4 (Registered Nurse) a unit manager. She checked the system for orders and stated that she does not see it was written. She stated that after the emergency, "they should have put the order in. Oxygen requires an order because it is considered to be a medication."

On 5/12/21 at 10:58 AM an interview was conducted with LPN #1 (Licensed Practical Nurse), who wrote the above note. She stated that she was in the resident's room at the time of the emergency situation and that the unit manager was in the room as well and was on the phone with the physician. She stated she did not hear the physician's side of the conversation but that the unit manager repeated what the physician was saying, and that the unit manager stated the resident was to get oxygen and that the rate was to be two liters. LPN #1 stated that she went and got the concentrator and hooked her up and the unit manager said she was going to put in the order. When asked to review the orders for oxygen, LPN #1 stated, "I do not see an order for

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oxygen. It should have been in there." LPN #1 stated that "Oxygen requires an order. It is a medication."

On 5/12/21 at 11:13 AM, ASM (Administrative Staff Member) #1, #2, #3, and #5 (the Administrator, the Director of Nursing, the Regional Director of Operations, and the Senior Clinical Transition Specialist) were made aware of the findings. No further information was provided.

6. Resident #333 was admitted to the facility on 2/15/21 and discharged to the hospital on 3/9/21 and did not return to the facility. The resident was admitted with the diagnoses of but not limited to left tibia fracture, pneumonia, obesity, diabetes, glaucoma, high blood pressure, chronic kidney disease, heart failure, end stage renal disease, dislocation of ankle joint, and dialysis. The 5-day MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/19/21 coded the resident as cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive assistance for transfers, dressing, toileting and hygiene; independent for eating; and was occasionally incontinent of bowel and bladder.

A review of the clinical record revealed the following notes:

- A nurse's note dated 3/8/21 at 10:14 AM documented, "Noted that guest complained of shortness of breath and abdominal pain. A set of vitals was obtained which was within normal limit except for her oxygen sats (saturation) which was 78% on room air. Oxygen administered briefly....She stated that she wanted to skip

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dialysis for today but nurse encouraged her to go. A second set of vitals obtained which was within normal limits and oxygen sats was 95%. Will continue to monitor."

- A physician's note dated 3/9/21 at 2:52 PM documented, "....S/P (status post) dialysis today, overall feeling week and C/O (complains of) some SOB (shortness of breath) noted she has low grade fever....BP (blood pressure) is high this morning....B/L (bilateral) mild exp. (expiratory) wheezing, no rhonchi....with new fever we check CXR (chest x-ray)....if have more fever or CXR is abnormal-will need to start antibiotics....discussed with daughter in detail...."

- A physician's note dated 3/9/21 at 11:25 AM documented, "....received call from nurse about CXR (chest x-ray) shows RUL (right upper lobe) pneumonia noted low grade fever oxygen saturation 92% with oxygen, Bp (blood pressure) is ok as per nurse feel week and low appetite plan: Levaquin (1) 750 (milligrams) now then Q 48 H (every 48 hours) after each dialysis, albuterol (2) MDI (metered dose inhaler) schedule and PRN (as needed), labs tomorrow morning, speech eval (evaluation), discuss with daughter (name) in detail, discuss with nurse and unit incharge."

- A nurse's note dated 3/9/21 at 12:22 PM documented, "Unit Manager talked with md (medical doctor) in reference to pts (patient's) status vital signs, abt (antibiotic) for pneunmonia (sic)....He stated that he spoke with (name), the next of kin which is her daughter in reference to the new antibiotic for pneumonia and pt [patient] is on oxygen."

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- A nurse's note dated 3/9/21 at 12:26 PM documented, "(Name of), daughter called today and wanted the md (Medical Doctor) to update. I spoke with the md and he had given (name of another daughter) the update, and she would be the contact family member. I spoke with her via phone and she stated she had been updated on her mothers status about oxygen and antibiotic for pneumonia."

- A nurse's note dated 3/9/21 at 2:00 PM documented, "Called MD (medical doctor) to notify him of the vital signs (temperature) 98.8, (blood pressure) 82/46, (pulse) 107, (oxygen saturation) level 89% on oxygen as ordered. Non-rebreather applied. Repeat (oxygen) level at 2:10pm is 75%. MD notified. Send patient out 911. RP (responsible party), daughter is aware."

- A nurse's note dated 3/9/21 at 3:09 PM documented, "This nurse observed guest as having a BS (blood sugar) of 57 nurse encouraged guest to drink some orange juice the aide assisted guest with her drink. upon getting a second set of BS it increased to 72. However guest was observed as having sob (shortness of breath) her O2 (oxygen) sats (saturation) were 89, oxygen was given at 5 liters and no improvement her vs (vital signs) (blood pressure) 82/46 (pulse) 107 O2 (oxygen saturation) 89 (temperature) 98.8. Patient primary was called Dr (doctor) (name) and he recommended that she be sent out to (name of) hospital verbal report was given, (Hospital nurse) the ER (Emergency Room) nurse stated she did not want the e-change of condition and e-interact transfer form to be faxed."

A review of the physician's orders failed to reveal

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any evidence that there was an order to administer the oxygen that was documented in the above notes.

The nurses involved in this change of condition were no longer at the facility and therefore could not be interviewed.

On 5/12/21 at 8:37 AM an interview was conducted with RN #4 (Registered Nurse) a unit manager. She checked the system for orders and stated that she does not see it was written. RN #4 stated that after the emergency, "they should have put the order in. Oxygen requires an order because it is considered to be a medication."

On 5/12/21 at approximately 12:15 PM, a phone interview was conducted with ASM #6 (Administrative Staff Member), the physician. He stated that he ordered the oxygen as the resident was having difficulties, and did not improve, so he sent the resident out to the hospital. ASM #6 stated the nurses were keeping him notified of the resident's status and the use of the oxygen and its effectiveness.

On 5/12/21 at 11:13 AM, ASM (Administrative Staff Member) #1, #2, #3, and #5 (the Administrator, the Director of Nursing, the Regional Director of Operations, and the Senior Clinical Transition Specialist) were made aware of the findings. No further information was provided.

References:

1. Levaquin - is an antibiotic. Information obtained from

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https://medlineplus.gov/druginfo/meds/a697040.html

2. Albuterol - is a bronchodilator used to treat symptoms of lung diseases such as asthma and chronic obstructive pulmonary disease. Information obtained from https://medlineplus.gov/druginfo/meds/a607004.html

7. Resident #6 was admitted to the facility on 2/7/20 with diagnoses that include but are not limited to:
Chronic respiratory failure (chronic inability of the heart and lungs to maintain an adequate gas exchange) (1), trach (surgically created opening into the trachea with a tube inserted to create an airway) (2) and Parkinson's disease (slowly progressive neurological disorder characterized by tremors) (3).

Resident #6's most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 2/2/21, coded the resident as scoring a 00 out of 15 on the BIMS (brief interview for mental status score), indicating the resident was severely cognitively impaired. The resident was coded as being totally dependent in bed mobility, transfers, dressing, toileting, bathing, personal hygiene and eating; walking/locomotion did not occur.

A review of the physician orders dated 2/9/21, documented in part, "Change inner cannula of disposable trach one time a day. Clean inner cannula every shift."

A review of the TAR (treatment administration record) from 4/1/21-5/12/21 documented in part, Change inner cannula of disposable trach one

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time a day. Clean inner cannula every shift." The TAR documented that the treatment was completed 100% of days.

Resident #6's care plan dated 6/5/20 and revised 1/6/21, documented in part, "NEED: Has a potential for difficulty breathing and risk for respiratory complications related to history of respiratory failure. Guest has trach. INTERVENTIONS: Change disposable trach cannula as ordered and as needed. Observe for signs/symptoms of acute respiratory insufficiency. Report abnormal findings to the physician. Oxygen at 2 liters nasal cannula for shortness of breath. Trach humidity set up with oxygen bleed to keep oxygen saturation greater than 90%."

On 5/11/21 at 8:20 AM, trach care was observed. LPN (licensed practical nurse) #5 changed the inner cannula of Resident #6's disposable trach, and cleaned the inner cannula. LPN #5 then changed dressing and suctioned the resident.

An interview was conducted on 5/11/21 at 8:50 AM with LPN #5. When asked what supplies were needed for a resident with a trach, LPN #5 stated, "We should have the inner cannula, extra trach, trach ties, dressing, trach kit, oxygen tubing and an ambu bag." When asked to observe the additional disposable trach, inner cannula and ambu bag, LPN #5 stated, "They are in his closet. I will show you." LPN #5 opened the closet and stated, "There is not an ambu bag in this closet. I thought there was one." When asked where the ambu bags were located, LPN #5 stated, in the supply room and on the code cart."

An interview was conducted on 5/11/21 at 1:15 pm with LPN #12. When asked if an ambu bag

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should be kept in the room of a resident with a trach, LPN #12 stated, "Yes, there should be one in the room for emergencies."

On 5/11/21 at 4:54 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of operations, were informed of the finding.

According to ASM #2, the director of nursing, the standard of practice followed is Lippincott, the on line version.

A review of the Lippincott's "Tracheostomy suctioning" procedure documents "Equipment: handheld resuscitation bag".

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 502.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 574.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 435.
(4). Ambu bag: A self-refilling bag-valve-mask unit with a 1-1.5 litre capacity, used for artificial respiration which, while suboptimal for the non-intubated patient, is effective for ventilating and oxygenating intubated patients, allowing both spontaneous and artificial respiration. This information was obtained from the website:

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F 695	Continued From page 112 https://medical-dictionary.thefreedictionary.com/Ambu+bag#:~:text=Ambu%20bag%20A%20self-refilling%20bag-valve-mask%20unit%20with%20a,respiration. %20Segen%27s%20Medical%20Dictionary. %20%C2%A9%202012%20Farlex	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to provide dialysis services, consistent with professional standards of practice, the comprehensive person-centered care plan two of 38 residents, Resident #22 and Resident #439. The facility staff failed to evidence consistent assessments of Resident #22 and Resident #439's dialysis access sites per the comprehensive plan of care. Resident #22 had no documented assessment of the residents dialysis access site for a bruit and thrill on multiple dates in March, April and May, 2021. Resident #439 had no documented assessment of the residents dialysis access site for a bruit and thrill from 12/1/20 through 1/15/21, (47 days). The findings include:	F 698	Resident #22 is no longer a resident. No negative outcome occurred from this practice. Resident #439 is no longer a resident. No negative outcome occurred from this practice. Residents receiving dialysis have the potential to be affected by this practice. DON/designee will review all orders for dialysis residents to ensure that orders are complete and clearly state where the site is and what kind of monitoring is required based on what type of dialysis site it is. Revisions will be made to orders as needed. Review of new admission orders for residents on dialysis services will also become part of clinical operations review to ensure orders and monitoring	6/15/21

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F 698	Continued From page 113 1. Resident #22 was admitted to the facility on 8/5/20. Resident #22's diagnoses included but were not limited to: ESRD [end stage renal disease] (inability of the kidneys to excrete wastes and function in the maintenance of electrolyte balance (1), diabetes mellitus (inability of insulin to function normally in the body) (2), atrial fibrillation (rapid and random contraction of the atria of the heart) (2) and peripheral vascular disease (abnormal conditions affecting blood vessels outside of the heart) (3). Resident #22's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/28/21, coded that the resident's BIMS (brief interview for mental status) a score of 11 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is moderately impaired cognitively. A review of the MDS Section G-functional status coded the resident as extensive assistance for bed mobility, transfers, dressing, hygiene; limited assistance with locomotion and eating total dependence for bathing. Walking did not occur. A review of MDS Section H- bowel and bladder coded the resident as frequently incontinent for bowel and for bladder. A review of the comprehensive care plan dated 2/22/20, documented in part, "NEED-at risk for complications related to dialysis due to ESRD. INTERVENTIONS-resident is receiving hemodialysis: palpate for presence of thrill and listen for bruit as needed. Observe for redness or swelling at the site. Report abnormal observations to physician as needed."	F 698	are correct on admission. DON or designee will educate licensed nursing staff on dialysis residents orders and specific monitoring of sites depending on where site is placed. DON or designee will audit dialysis resident's orders and MARS/TARS weekly for 4 weeks. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the Quality Assurance Committee. Continued compliance will be monitored through the quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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A review of the TAR (treatment administration record) "Check bruit and thrill left upper arm shunt every shift". The TAR 3/1/31 failed to evidence bruit and thrill checks for the dialysis shunt for 16 of 93 shifts, the 4/1/21-4/30/21 TAR failed to evidence bruit and thrill checks for the dialysis shunt for 11 of 90 shifts and the 5/1/21-5/10/21 TAR failed to evidence bruit and thrill checks for 1 of 30 shifts.

An interview was conducted on 5/10/21 at 3:05 PM with LPN (licensed practical nurse) #12. When asked about the care for a resident with a dialysis shunt, LPN #12 stated, "We check for a bruit and thrill. We should check it every shift." When asked if this was documented, LPN #12 stated, "Yes it is on the TAR."

An interview was conducted on 5/10/21 at 3:25 PM with LPN #15, the unit manager. When asked about the care for a resident with a dialysis shunt, LPN #15 stated, "We check for a bruit and thrill." When asked the frequency of these checks, LPN #15 stated, "We should check it on days of dialysis. We probably should check it every day." When asked if this was documented, LPN #15 stated, "Yes it is documented on the TAR." When asked if it not documented, what that means, LPN #15 stated, "It means that it wasn't documented, not that it wasn't done."

2. Resident #439 was admitted to the facility on 2/19/20 with diagnosis that included but were not limited to: diabetes mellitus (inability of insulin to function normally in the body) (2), atrial fibrillation (rapid and random contraction of the atria of the heart) (4), renal failure (inability of the kidneys to excrete waste and function in the maintenance of

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electrolyte balance) (5), and bipolar (mental disorder characterized by periods of mania and depression) (6).

The most recent MDS (minimum data set) assessment, a five day admission Medicare assessment, with an ARD (assessment reference date) of 1/6/21, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, transfer, hygiene, bathing and dressing; independence for eating, locomotion and walking did not occur. A review of MDS Section H- bowel and bladder coded the resident as always frequently incontinent for bowel and occasionally incontinent for bladder.

A review of the comprehensive care plan dated 2/20/20, documented in part, "NEED-at risk for complications related to dialysis. INTERVENTIONS-resident is receiving hemodialysis: palpate for presence of thrill and listen for bruit as needed. Observe for redness or swelling at the site. Report abnormal observations to physician as needed."

A review of the TAR (treatment administration record) from 12/1/20-1/15/21 failed to evidence bruit and thrill checks for Resident #439's dialysis shunt." There was no documentation of bruit and thrill checks for 47 days.

An interview was conducted on 5/11/21 at 8:50 AM with LPN (licensed practical nurse) #5. When asked the care for a resident with a dialysis shunt, LPN #5 stated, "You should check for a

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bruit and thrill. We check it every shift." When asked if this was documented, LPN #5 stated, "Yes it is on the TAR."

On 5/11/21 at 4:54 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of operations, were informed of the finding.

According to ASM #2, the director of nursing, the standard of practice followed is Lippincott, the on line version.

According to Medical Surgical Nursing made Incredibly Easy, Lippincott Williams & Wilkins copyright 2004 page 565 Dialysis Monitoring and Aftercare: "At least four times per day, assess circulation at the access site by auscultating for the presence of bruits and palpating for thrills. Unlike most other circulatory assessments, bruits and thrills should be present here. Lack of a bruit at a venous access site ...may indicate a blood clot requiring immediate surgical attention."

No further information was provided prior to exit.

Complaint Deficiency

References:

(1) Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 498.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 160.
(3) Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 445.
(4) Barron's Dictionary of Medical Terms for the

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F 698	Continued From page 117 Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 54. (5) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 498. (6) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 71	F 698		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, resident interviews, staff interviews, clinical record reviews and facility document reviews it was determined that the	F 700	Resident #57 is no longer at the facility. No negative outcome occurred from this practice.	6/15/21

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F 700	Continued From page 118 facility staff failed to implement bed rail requirements for four of 38 residents in the survey sample, Residents #57, #132, #58 and #64. The facility staff failed to perform a physical device assessment, obtain a physician's order, obtain a consent for bed rails and evidence documentation of the use of bed rails on the comprehensive care plan for Resident #57, and Resident #58, and failed to obtain a consent prior to the use of bed rails for Resident #132, and failed to evidence an assessment for the use of bed rails [also referred to as side rails] for Resident # 64. The findings include: 1. Resident #57 was admitted to the facility with diagnoses that included but were not limited to metabolic encephalopathy (1), dementia (2) and osteoarthritis (3). Resident #57's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/15/2021, coded Resident #57 as scoring a 3 (three) on the staff assessment for mental status (BIMS) with a score of 0 - 15, 3- being severely impaired for making daily decisions. Section G coded Resident #57 requiring extensive assistance of two or more staff for bed mobility, transfers and dressing. On 5/10/2021 at approximately 11:50 a.m., Resident #57 was observed in bed with bilateral upper bed rails in place on the bed. The bed rails were observed up and Resident #57 was observed to grasp the bed rail when turning to the side in bed. An interview was attempted with Resident #57, however Resident #57 failed to	F 700	Resident #58 was reassessed and is not appropriate for side rail use. Side rails were tied down per TELS work order. No negative outcome occurred from this practice. Resident #132 is no longer at the facility. No negative outcome occurred from this practice. Resident #64 does have an order for side rails. An assessment and consent for use was obtained. Resident remains appropriate for side rail use. Residents with side rails in the facility have the potential to be affected. DON or designee will educate licensed nursing staff on the policy/process for bedrails and entrapment, to include device evaluation, risk vs. benefit and consent and order. DON/designee has conducted an audit of current resident beds. An updated physical device evaluation will be completed for all residents; and order and risk versus benefit and consent will be obtained for residents using side rails. DON/designee will monitor new orders for side rails 5 times per week for 1 week, 3 times a week for 3 weeks, and weekly for 1 month and monthly for 1 month. Any variances will be corrected and additional education and/or counseling will be provided as indicated. Concerns will be	

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F 700	Continued From page 119 answer questions appropriately. Additional observations of Resident #57 on 5/10/2021 at approximately 4:15 p.m. and 5/11/2021 at approximately 8:30 a.m. revealed the resident in bed with the bilateral bed rails up. The physician orders for Resident #57 failed to evidence an order for the use of bed rails. The comprehensive care plan for Resident #57 dated "3/11/2021" failed to evidence documentation for use of bed rails. Review of Resident #57's clinical record failed to evidence a physical device assessment or consent for use of bed rails. On 5/11/2021 at approximately 11:30 a.m., ASM (administrative staff member) #1, the administrator provided via email, documentation of bed rail inspections completed in the facility for the past twelve months. The document provided documented the bed in Resident #57's room having bed rails being inspected by maintenance staff on "Week 4 June 2020." On 5/12/2021 at approximately 7:45 a.m., a request was made via a written list to ASM #1, for the physical device assessment, consent for bed rail use and care plan for use of bed rails for Resident #57. On 5/12/2021 at approximately 9:30 a.m., ASM #1 stated that there was no order, consent or assessment for the bed rails for Resident #57. ASM #1 stated that Resident #57 should not have had the bed rails and they had no documentation to provide.	F 700	reported by the DON/designee to the Quality Assurance Committee. Continued compliance will be monitored through the quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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On 5/12/2021 at approximately 10:33 a.m., an interview was conducted with LPN (licensed practical nurse) #4, the unit manager. LPN #4 stated that residents were evaluated for the use of bed rails to determine if they were able to use them for repositioning or turning in bed by the physical device assessment. LPN #4 stated that if a resident were assessed as eligible for bed rails they discussed the risks and benefits of the use and if they agreed to have them, they would sign a consent to authorize them. LPN #4 stated that if the resident were unable to make the decision for bed rails they discussed them with the responsible party and had them sign the consent for use. LPN #4 stated that after the physical device assessment was completed and the consent was obtained from the resident or the responsible party, they obtained a physician order for the bed rails and had the bed rails put into use. LPN #4 stated that they would also care plan the bed rails at that time.

On 5/12/2021 at approximately 11:15 a.m., a request was made to ASM #1 for the facility policy on use of bed rails.

The facility policy, "Restraint Management" dated "Revised: 10/2019" documented in part, "... 1. Whenever a guest/resident is admitted with an order for a restraint (including side rails), the staff may accept the order for up to 72 hours pending completion of the Physical Device Evaluation. 2. When a guest's/resident's condition necessitates consideration for a restraint, alternative interventions must be attempted and documented on the Physical Device Evaluation and in the care plan...5. Any guest/resident using a physical restraint or side rails must have a current, signed

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restraint consent in the medical record..." The policy further documented, "...10. Any guest using side rails will have a current order with the following components: Type of side rails (1/2, 3/4, full, assist bars); Number of side rails to be raised; Reason for use/medical symptom; Guest/resident request for use of side rails (If applicable)..."

On 5/12/2021 at approximately 11:15 a.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of operations and ASM #5, the senior clinical transition specialist were made aware of the findings.

No further information was provided prior to exit.

Reference:

1. Encephalopathy: "Encephalopathy is a general term describing a disease that affects the function or structure of your brain." This information is taken from the website https://www.healthline.com/health/hepatic-encephalopathy.

2. Dementia: A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

3. Osteoarthiris- Osteoarthritis occurs when cartilage, the tissue that cushions the ends of the bones within the joints, breaks down and wears away. In some cases, all of the cartilage may wear away, leaving bones that rub up against each other. This information was obtained from

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the website:
https://www.nia.nih.gov/health/osteoarthritis.

2. Resident #132 was admitted to the facility with diagnoses that included but were not limited to sepsis (1) and cardiomyopathy (2). Resident #132's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 4/25/2021, coded Resident #132 as scoring a 14 on the staff assessment for mental status (BIMS) with a score of 0 - 15, 14- being cognitively intact for making daily decisions. Section G coded Resident #132 requiring extensive assistance of two or more staff for bed mobility and total dependence of two or more staff for transfers.

On 5/10/2021 at approximately 11:40 a.m., Resident #132 was observed in bed asleep with bilateral upper bed rails in place on the bed. The bed rails were observed up.

On 5/11/2021 at approximately 11:45 a.m., an interview was conducted with Resident #132. Resident #132 was observed in bed with bilateral upper bed rails up. Resident #132 stated that they used the bed rails to hold onto when staff provided care and to assist in repositioning themselves in the bed. Resident #132 stated that they did not recall signing a consent for the bed rails but they wanted them on the bed and used them.

The physician orders for Resident #132 documented in part, "Two 1/2 (half) side rails up as an enabler when in bed. Order Date: 4/21/2021."

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The physical device assessment for Resident #132 dated 4/21/2021 documented in part, "...Reason for enabler device use, 1. Repositioning/Support 2. Enable/Increase bed mobility. 7. New or Revised Order Two 1/2 side rails up as an enabler when in bed. 8. Care plan updated, Yes..."

The comprehensive care plan for Resident #132 dated 4/21/2021 documented in part, "[Resident #132] is at risk for fall related injury and falls R/T (related to) limited mobility and weakness, use of antidepressant. Date Initiated: 04/21/2021. Revision on: 05/03/2021." Under "Interventions" it documented in part, "...two 1/2 siderails [also know as bedrails] up in bed as an enabler. Date Initiated: 04/22/2021."

On 5/11/2021 at approximately 11:30 a.m., ASM (administrative staff member) #1, the administrator provided via email, documentation of bed rail inspections completed in the facility for the past twelve months. The document provided documented the bed in Resident #132's room having bed rails being inspected by maintenance staff on "Week 4 June 2020."

On 5/12/2021 at approximately 7:45 a.m., a request was made via a written list to ASM #1, for the consent for use of bed rails for Resident #132.

On 5/12/2021 at approximately 9:30 a.m., ASM #1 stated that they were emailing the bed rail documentation for Resident #132.

On 5/12/2021 at approximately 10:07 a.m., ASM #1 provided the physical device assessment dated 4/21/2021 and the physician's order for bed

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rails dated 4/21/2021. The email documents failed to evidence a consent for the use of bed rails.

On 5/12/2021 at approximately 10:33 a.m., an interview was conducted with LPN (licensed practical nurse) #4, the unit manager. LPN #4 stated that residents were evaluated for the use of bed rails to determine if they were able to use them for repositioning or turning in bed. LPN #4 stated that if a resident were assessed as eligible for bed rails they discussed the risks and benefits of the use and if they agreed to have them, they would sign a consent to authorize them. LPN #4 stated that if the resident were unable to make the decision for bed rails they discussed them with the responsible party and had them sign the consent for use. LPN #4 stated that after the assessment was completed and the consent was obtained they obtained a physician order for the bed rails and had the bed rails put into use.

On 5/12/2021 at approximately 11:15 a.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of operations and ASM #5, the senior clinical transition specialist were made aware of the findings.

No further information was provided prior to exit.

Reference:

1. Sepsis: An illness in which the body has a severe, inflammatory response to bacteria or other germs. The symptoms of sepsis are not caused by the germs themselves. Instead, chemicals the body releases cause the response. This information was obtained from the website:

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<https://medlineplus.gov/ency/article/000666.htm>.

2. Cardiomyopathy: Disease in which the heart muscle becomes weakened, stretched, or has another structural problem. It often occurs when the heart cannot pump or function well. Most people with cardiomyopathy have heart failure. This information was obtained from the website: https://medlineplus.gov/ency/article/001105.htm.
3. Resident # 58 was admitted to the facility with diagnoses that included but were not limited to: acute and chronic respiratory failure [1] and chronic obstructive pulmonary disease [2] and muscle weakness. Resident # 58's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 03/16/2021, coded Resident # 58 as scoring an 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 - being cognitively intact for making daily decisions. Under section "G Functional Status" coded Resident # 58 as requiring extensive assistance of one staff member for bed mobility.

On 05/10/2021 at 1:52 p.m., and 05/11/2021 at 7:58 a.m., observation revealed Resident # 58 lying in bed with right and left upper bed rails raised.

The comprehensive care plan for Resident # 58 dated 07/16/2020 failed to evidence documentation for the use of bedrails.

Review of the EHR (electronic health record) for Resident # 58 failed to evidence documentation of an assessment for the use of bedrails.

On 05/12/2021 at 10:15 a.m., an interview was

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conducted with Resident # 58. When asked if they could reposition themselves in the bed, Resident # 58 stated, "No, I need help."

On 05/12/2021 at 10:45 a.m., an interview was conducted with LPN (licensed practical nurse) #4, unit manager, regarding Resident # 58's use of bedrails. LPN #4 stated that Resident # 58 was unable to reposition themselves and the bedrails should not be in the raised position. LPN # 4 further stated that they had contacted the maintenance department and earlier in the day [OSM -other staff member # 7, director of maintenance] secured the bedrails in the down position so they could not be raised.

On 05/12/2021 at 11:00 a.m., an observation of Resident # 58's bedrails was conducted with OSM # 7. Observation of the bedrails revealed they were in the down position and secure with cable ties [3]. Attempts made to raise the bedrails were unsuccessful evidencing that they were secured in the down position.

On 05/12/2021 at approximately 11:15 a.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, ASM # 3, regional director of operations and ASM # 4, senior clinical transition specialist, were made aware of the above findings.

No further information was provided prior to exit.

References:
[1] When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html.

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[2] Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

[3] A cable tie, also known as a zip tie or tie-wrap, is a type of fastener, designed for bunching electric cables or wires and to organize cables and wires, but with a wide variety of other applications. In its common form, the nylon cable tie consists of a tape section with triangular teeth that slope in one direction. The head of the cable tie has a slot with a flexible pawl that irreversibly rides up the slope of these teeth when the tape is inserted. The pawl engages the backside of these teeth to stop removal of the tape. This information was obtained from the website: https://www.definitions.net/definition/CABLE+TIE

4. Resident # 64 was admitted to the facility with diagnoses that included but were not limited to: heart disease, pressure ulcer and arthritis. Resident # 64's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 03/21/2021, coded Resident # 64 as scoring a 13 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 - being cognitively intact for making daily decisions. Section G coded Resident # 64 as being totally dependent of two staff members for bed mobility.

On 05/10/2021 at 3:38 p.m., and 05/11/2021 at 8:10 a.m., observation revealed Resident # 64 lying in bed with right and left upper bed rails raised.

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On 05/11/21 at 10:20 a.m., an observation of Resident # 64's wound care was conducted. During the observation Resident # 64 was observed holding onto the left upper bedrail to stabilize herself on their left side, with the assistance of a certified nursing assistant, while wound care was conducted.

The physician's orders for Resident # 64 documented in part, "Resident to have bilat [bilateral] ½ [half] side rails to aide in turning and repositioning."

The comprehensive care plan for Resident # 64 dated 03/17/2021 documented in part, "Need: [Resident # 64] has an ADL [activities of daily living] Self Care Performance Deficit and requires assistance with ADL's and mobility. Date Initiated: 03/17/2021." Under "Interventions" it documented in part, 'Half bilateral side rails to aide in turning and repositioning. Date Initiated: 03/17/2021."

Review of the EHR (electronic health record) for Resident # 64 failed to evidence an assessment for the use of bedrails.

On 05/12/2021 at 10:45 a.m., an interview was conducted with LPN (licensed practical nurse) #4, unit manager, regarding Resident # 64's assessment for the use of bedrails. After reviewing Resident # 64's HER [electronic health record] LPN # 4 stated that an assessment was not completed.

On 05/12/2021 at approximately 11:15 a.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, ASM # 3, regional director of operations and ASM # 4, senior clinical

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F 700	Continued From page 129 transition specialist, were made aware of the above findings. No further information was provided prior to exit.	F 700		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to complete the required annual performance review for two of five CNA (certified nursing assistant) records reviewed, CNAs #1 and #3. For CNA #1, no performance evaluation was completed between 3/7/20 and 3/7/21, and for CNA #3, no performance evaluation was completed between 6/11/19 and 6/11/20. The findings include: A review of performance evaluations was performed for CNA #1 and #3. On 5/11/21 at 9:45 a.m., ASM (administrative staff member) #1, the administrator, stated she had not located the annual performance review for CNA #1, but believed the review for CNA #3 was on her desk. On 5/11/21 at 4:45 p.m., ASM #1 was asked about the status of the performance reviews for both CNA #1 and CNA #3. She stated ASM #2,	F 730	Performance reviews were completed for CNA#1 and CNA#3. All current certified nursing assistants have the potential to be affected. BOM or designee will pull a list of certified nursing assistants that have been employed > 1 year and determine if all evaluations are timely. Administrator or designee will in-service nursing administration on the need to get evaluations of CNAs completed within 1 year. BOM or designee will audit evaluation list put out to ensure evaluations are done timely and returned. This audit will be done monthly. Any variances will be corrected and additional education and/or counseling will be provided as indicated.	6/15/21

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F 730	Continued From page 130 the director of nursing, was responsible for these reviews, and should be interviewed. On 5/12/21 at 10:58 a.m., ASM #2, the director of nursing, was interviewed about the missing performance reviews for CNAs #1 and #3. She stated the payroll department prints out a list of which reviews are due for a particular month. ASM #2 stated, "We try to complete those first." She stated unit managers and the assistant director of nursing are responsible for helping her complete the required annual performance reviews. She could not state a reason for these two performance reviews not being completed. ASM #2 stated the reviews are important to give staff feedback, to determine if a performance improvement plan is needed, and are an effective means of one-on-one communicating with an employee. On 5/12/21 at 11:14 a.m., ASM #1 and ASM #3, the regional director of operations spoke about the evaluations that were not completed. ASM #1 stated there was no facility policy regarding the evaluations. ASM #3 stated the timing of the evaluations, per company practice, was linked to staff wage increases. No further information was provided prior to exit.	F 730	Concerns will be reported by the Administrator to the Quality Assurance Committee. Continued compliance will be monitored through the quality assurance program. Additional education and monitoring will be initiated for any identied concerns.	
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including	F 757		6/15/21

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F 757	Continued From page 131 duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and facility document review it was determined the facility staff failed to ensure the drug regimens for three of 38 residents in the survey sample, (Residents #15, #58 and # 63), were free from unnecessary medications. The facility staff failed to implement and attempt non-pharmacological interventions per the physician's orders and plan of care prior to administering as needed (prn) pain medications to Resident #15, Resident #58 and Resident #63 on multiple dates during April and May 2001. The findings include: 1. Resident # 15 was admitted to the facility with diagnoses that include but not limited to: spinal stenosis [2]. Resident # 15's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of	F 757	Resident #15 received a drug regimen review to specifically address PRN pain medication. Resident #58 received a drug regimen review to specifically address PRN pain medication. Resident #63 received a drug regimen review to specifically address PRN pain medication. Resident on PRN pain medication are potentially at risk for unnecessary medications. DON or designee will educate licensed nursing staff on following non-pharmacological interventions for pain prior to administering pain medication and documentation needed.	

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F 757	Continued From page 132 02/05/2021, coded Resident # 15 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Section "J0300, J0400 and J0600 Pain Assessment Interview" coded Resident # 15 as not having pain in the past five days`. The physician's order for Resident # 15 dated 02/02/2021 documented, "Oxycodone Tablet 5 MG [five milligrams]. Give 1 [one] tablet by mouth every 6 [six] hours as needed for pain, pain scale 6-10 [six to ten]. Order Date: 2/2/2021." "Pain-Non-Pharmacological Interventions: Document Non Pharmacological interventions used: 1) Massage. 2) Meditation/Relaxation. 3) Positioning. 4) Ice/cold pack. 5) Diversional Activity. 6) Guided Imagery. 7) Rest. 8) Social Interaction. 9) Other _____. Document Non-Pharmacological interventions using the corresponding number. Order Date: 2/2/2021." Resident # 15's eMAR [electronic medication administration record] dated April 2021 documented the physician's order as stated above. The eMAR failed to evidence documentation of non-pharmacological interventions prior to the administration of oxycodone on: 04/01/2021 at 12:13 p.m. with a level of six, 04/02/2021 at 12:42 p.m. with a pain level of seven, 04/04/2021 at 8:38 a.m. with a pain level of seven, 04/05/2021 at 1:03 p.m. with a pain level of six and at 10:10 p.m. with a pain level of seven, 04/06/2021 at 1:19 p.m. with a pain level of seven, 04/07/2021 at 12:44 p.m. with a pain level of six, 04/10/2021 at 12:57 p.m. with a pain level of seven and at 9:41 p.m. with a pain level of seven, 04/14/2021 at 12:46 p.m. with a	F 757	DON or designee will audit residents who have orders for PRN pain medication to ensure non-pharmacological interventions are addressed and in the order with a place to document this on Medication Administration Record (MAR). Nursing administration will monitor non-pharmacological interventions for PRN pain medications weekly for 4 weeks. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/designee to the Quality Assurance Committee. Continued compliance will be monitored through the quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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pain level of six, 04/15/2021 at 4:13 p.m. with a pain level of ten, 04/18/2021 at 3:45 a.m. with a pain level of six, 04/21/2021 at 5:55 a.m. with a pain level of eight, 04/24/2021 at 10:28 a.m. with a pain level of seven and at 10:14 p.m. with a pain level of eight, 04/25/2021 at 4:03 p.m. with a pain level of seven and on 04/27/2021 at 10:28 p.m. with a pain level of eight.

Resident # 15's eMAR [electronic medication administration record] dated May 2021 documented the physician's order as stated above. The eMAR failed to evidence documentation of non-pharmacological interventions prior to the administration of oxycodone on: 05/04/2021 at 3:15 p.m. with a pain level of seven, 05/05/2021 at 10:20 p.m. with a pain level of six and on 05/09/2021 at 4:15 p.m. with a pain level of eight and at 10:11 p.m. with a pain level of seven.

The comprehensive care plan for Resident # 15 dated 07/16/2020 documented in part, "Need: [Resident # 15 is at risk for pain and/or has acute/chronic pain r/t [related to] Arthritis, spinal stenosis. Date Initiated: 07/16/2020." Under "Interventions" it documented in part, "Offer Non-Pharmacological Interventions: 1) Massage. 2) Meditation/Relaxation. 3) Positioning. 4) Ice/cold pack. 5) Diversional Activity. 6) Guided Imagery. 7) Rest. 8) Social Interaction. 9) Other. Date Initiated: 07/16/2020"

On 05/10/21 at 1:56 p.m., an interview was conducted with Resident # 15. When asked if they received pain medication when needed Resident # 15 stated yes. When asked if the nurses try to alleviate the pain before administering the medication, Resident # 15

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stated, "Sometimes they do."

On 05/11/21 at 2:27 p.m., an interview was conducted with LPN [licensed practical nurse] # 4, unit manager regarding as needed pain and the implementation of non-pharmacological interventions. When asked where a nurse documents that non-pharmacological interventions were attempted prior to administering a as needed pain medication, LPN # 4 stated, "Should be documented on the eMAR." After reviewing Resident # 15's April 2021 and May 2021 eMARs, LPN # 4 stated that there was missing documentation of non-pharmacological interventions on the dates and times documented above. LPN # 4 further stated that they couldn't say that the interventions were being attempted. When asked why they should try non-pharmacological interventions prior to administering a pain medication LPN stated, "They may not need the pain medication."

The facility's policy "Pain Management" documented in part, "Procedure: 14. The staff will implement the care plan, monitor the guest/resident, and administer therapeutic interventions for pain, if ordered."

On 05/11/2021 at approximately 4:45 a.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, and ASM # 3, regional director of operations, were made aware of the above findings.

No further information was provided prior to exit.

References:
[1] Indicated for the management of pain severe enough to require an opioid analgesic and for

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which alternative treatments are inadequate. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=f2137f1a-b49a-40bd-97ac-cd6b36e295f4.

[2] A narrowing of the spinal column that causes pressure on the spinal cord, or narrowing of the openings (called neural foramina) where spinal nerves leave the spinal column. This information was obtained from the website: https://medlineplus.gov/ency/article/000441.htm.

2. The facility staff failed attempt non-pharmacological interventions prior to the administration of the prescribed as needed pain medication, oxycodone [1] to Resident # 58.

Resident # 58 was admitted to the facility with diagnoses that included but were not limited to: lower back pain. Resident # 58's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 03/16/2021, coded Resident # 58 as scoring an 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 - being cognitively intact for making daily decisions. Section "J0300, J0400 and J0600 Pain Assessment Interview" coded Resident # 58 as having frequent pain at a level four based on a zero to ten pain scale, with ten being the worse pain they could imagine.

The physician's order for Resident # 58 dated 01/14/2020 documented, "Oxycodone Tablet 5 MG [five milligrams]. Give 5 mg by mouth every 6 [six] hours as needed for severe pain. Order Date: 1/14/2020." "Pain-Non-Pharmacological Interventions: Document Non Pharmacological

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interventions used: 1) Massage. 2) Meditation/Relaxation. 3) Positioning. 4) Ice/cold pack. 5) Diversional Activity. 6) Guided Imagery. 7) Rest. 8) Social Interaction. Document Non-Pharmacological interventions using the corresponding number. Order Date: 2/12/2020."

The comprehensive care plan for Resident # 58 dated 07/16/2020 documented in part, "Need: [Resident # 58] has the potential for pain and general discomfort. Dx [diagnosis] of arthritis. Date initiated 05/04/2020." Under "Interventions" it documented in part, "Notify physician if interventions are unsuccessful or if current complaint is a significant change from resident's past experience of pain. Date initiated 05/04/2020."

Resident # 58's eMAR [electronic medication administration record] dated April 2021 documented the physician's order as stated above. The eMAR failed to evidence documentation of non-pharmacological interventions prior to the administration of the prescribed as needed pain medication oxycodone on: 04/09/2021 at 5:49 a.m. with a pain level of ten and on 04/19/2021 at 9:17 p.m. with a pain level of five.

Resident # 58's eMAR [electronic medication administration record] dated May 2021 documented the physician's order as stated above. The eMAR failed to evidence documentation of non-pharmacological interventions prior to the administration of the prescribed as needed pain medication oxycodone on: 05/04/2021 at 9:20 p.m. with a pain level of seven and on 05/08/2021 at 10:02 p.m. with a pain level of seven.

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On 05/10/21 at 1:44 p.m., an interview was conducted with Resident # 58. When asked if they received pain medication when needed, Resident # 58 stated yes. When asked if the nurses try to alleviate the pain before administering the medication, Resident # 58 stated, "Sometimes they do sometimes they don't."

On 05/11/21 at 2:27 p.m., an interview was conducted with LPN [licensed practical nurse] # 4, unit manager regarding as needed pain and the implementation of non-pharmacological interventions. When asked where a nurse documents that non-pharmacological interventions were attempted prior to administering a as needed pain medication LPN # 4 stated, "Should be documented on the eMAR." After reviewing Resident # 58's April 2021 and May 2021 eMARs LPN # 4 stated that there was missing documentation of non-pharmacological interventions on the dates and times documented above. LPN # 4 further stated that they couldn't say that the interventions were being attempted. When asked why they should try non-pharmacological interventions prior to administering a pain medication, LPN stated, "They may not need the pain medication."

On 05/11/2021 at approximately 4:45 a.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, and ASM # 3, regional director of operations, were made aware of the above findings.

No further information was provided prior to exit.

References:

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[1] Indicated for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=f2137f1a-b49a-40bd-97ac-cd6b36e295f4.

3. The facility staff failed attempt non-pharmacological interventions prior to the administration of as needed pain medication of acetaminophen [1] to Resident # 63.

Resident # 63 was admitted to the facility with diagnoses that included but were not limited to: fracture of the tibia [2]. Resident # 63's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 03/21/2021, coded Resident # 63 as scoring an 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 - being cognitively intact for making daily decisions. Section "J0300, J0400 and J0600 Pain Assessment Interview" coded Resident # 63 as having frequent pain at a level seven based on a zero to ten pain scale, with ten being the worse pain they could imagine.

The physician's order for Resident # 63 dated 03/16/2021 documented,
"Acetaminophen Tablet 325 MG [five milligrams]. Give 2 [two] tablets by mouth every 4 [four] hours as needed for severe pain and Give 2 tablets by mouth every 4 hours as needed for Temp [temperature 100F [One hundred degrees Fahrenheit] or above Order Date: 3/16/2021 ."
"Pain-Non-Pharmacological Interventions:

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Document Non Pharmacological interventions used: 1) Massage. 2) Meditation/Relaxation. 3) Positioning. 4) Ice/cold pack. 5) Diversional Activity. 6) Guided Imagery. 7) Rest. 8) Social Interaction. Document Non-Pharmacological interventions using the corresponding number. Order Date: 3/16/2021."

The comprehensive care plan for Resident # 63 dated 03/16/2021 documented in part, "Need: [Resident # 63] is at risk for pain and/or has acute/chronic pain r/t [related to] recent falls, tibia fracture. Date Initiated: 03/16/2021." Under "Interventions" in documented in part, "Offer Non-Pharmacological Interventions: 1) Massage. 2) Meditation/Relaxation. 3) Positioning. 4) Ice/cold pack. 5) Diversional Activity. 6) Guided Imagery. 7) Rest. 8) Social Interaction. 9) Other. Date Initiated: 03/16/2021."

Resident # 63's eMAR [electronic medication administration record] dated April 2021 documented the physician's order as stated above. The eMAR failed to evidence documentation of non-pharmacological interventions prior to the administration of Acetaminophen on: 04/02/2021 at 6:04 p.m. with a pain level of eight, 04/04/2021 at 11:23 a.m. with a pain level of six and at 8:40 p.m. with a pain level of five, 04/08/2021 at 9:14 a.m. with a pain level of eight, 04/10/2021 at 9:38 a.m. with a pain level of six and at 3:51 p.m. with a pain level of six, 04/11/2021 at 5:25 p.m. with a pain level of five, 04/13/2021 at 1:39 p.m. with a pain level of eight, 04/ 14/2021 at 8:17 a.m. with a pain level of six, 04/15/2021 at 10:38 a.m. with a pain level of five, 04/16/2021 at 9:15 p.m. with a pain level of five, 04/19/2021 at 9:21 a.m. with a pain level of seven, 04/22/2021 at 4:38 p.m. with a pain level

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of three, 04/ 23/2021 at 10:47 a.m. with a pain level of four and at 6:22 p.m. with a pain level of seven, 04/24/2021 at 10:55 a.m. with a pain level of seven. Further review of the eMAR revealed that Resident # 63 did not receive acetaminophen for temperature over 100 degrees.

On 05/10/21 at 11:16 a.m., an interview was conducted with Resident # 63. When asked if they received pain medication when needed Resident # 63 stated yes. When asked if the nurses try to alleviate the pain before administering the medication, Resident # 63 stated," No they just give me the medication."

On 05/11/21 at 2:27 p.m., an interview was conducted with LPN [licensed practical nurse] # 4, unit manager regarding as needed pain and the implementation of non-pharmacological interventions. When asked where a nurse documents that non-pharmacological interventions were attempted prior to administering a as needed pain medication LPN # 4 stated, "Should be documented on the eMAR." After reviewing Resident # 63's April 2021 eMAR LPN # 4 stated that there was missing documentation of non-pharmacological interventions on the dates and times documented above. LPN # 4 further stated that they couldn't say that the interventions were being attempted. When asked why they should try non-pharmacological interventions prior to administering a pain medication LPN stated, "They may not need the pain medication."

On 05/11/2021 at approximately 4:45 a.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, and ASM # 3, regional director of operations, were made aware

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F 757	Continued From page 141 of the above findings. No further information was provided prior to exit. References: [1] Used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). This information was obtained from the website: https: https://medlineplus.gov/druginfo/meds/a681004.html. [2] The tibia is the larger of two long bones in the lower leg. It is sometimes called the shin bone. This information was obtained from the website: https://medlineplus.gov/ency/article/002335.htm.	F 757		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident	F 842		6/15/21

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that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-

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F 842	Continued From page 143 (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to evidence a complete and accurate medical record for two of 38 residents in the survey sample, Resident #71 and Resident #333. The findings include: 1. For Resident #71, the facility staff failed to (A) ensure the comprehensive care plan goals for dialysis did not contain goals that were not appropriate for the type of dialysis access site the resident had in place; and (B) failed to ensure all medications and treatments were documented on the March 2021 and April 2021 Medication Administration Record (MAR). Resident #71 was admitted to the facility on 3/20/21 and readmitted on 4/23/21 with the diagnoses of but not limited to acute respiratory failure, gastrostomy, below knee amputation (right), end stage renal disease, chronic obstructive pulmonary disease, deep vein thrombosis, dialysis, chronic kidney disease, dysphagia, aphasia, diabetes, depression,	F 842	Resident #71: orders have been updated for the type of dialysis access site resident has. Care plan interventions have been updated to reflect this type of site. Resident #333: no longer resides at the center. The screening for mental illness that did not belong in this chart has been pulled from the chart. All residents are potentially affected. DON/designee will educate licensed nursing staff on dialysis residents orders and specific monitoring of sites depending on where site is placed. Licensed Nurses will also be in-serviced on documenting medications and treatments on the MARS/TARS. Administrator will in-service Medical Records Coordinator on checking records to be scanned to ensure being scanned to appropriate record. DON or designee will audit dialysis	

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F 842	Continued From page 144 dementia, osteomyelitis, and COVID-19. The 5-day MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 4/28/21 coded the resident as severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing and toileting; extensive assistance for transfers, dressing, eating, and hygiene; and was incontinent of bowel and bladder. (A) The facility staff failed to ensure the comprehensive care plan goals for dialysis did not contain goals that were not appropriate for the type of dialysis site the resident had. A review of the clinical record revealed a physician's order dated 4/28/21 for "Check Right chest dialysis port for bleeding post dialysis every day shift every Tue (Tuesday), Thu (Thursday), Sat (Saturday)." This order indicated the resident had a venous catheter (1) site for dialysis. A review of the comprehensive care plan revealed one dated 1//6/21 for "(Resident #71) is at risk for complications R/T (related to) needs dialysis due to: End Stage Renal Disease." The interventions included one dated 3/22/21 for "Do not draw blood or take B/P (blood pressure) in arm with graft (2)" and another one dated 3/22/21 for "For Hemodialysis: Check bruit/thrill (3) every shift. Notify physician if not detected." (Note: A bruit and thrill are not checked for catheter sites in the neck or chest. This procedure is for graft sites in the arm, which was not the type the resident had.)	F 842	resident's orders and MARs/TARs weekly for 4 weeks. The administrative nurses will audit current resident medication records weekly for 4 weeks to ensure that medication administered is documented. Administrator will audit a group of scanned records weekly for accuracy. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the Quality Assurance Committee. Continued compliance will be monitored through the quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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On 5/12/21 at 8:45 AM an interview was conducted with RN #3 (Registered Nurse), the MDS nurse. She reviewed the care plan and stated that these interventions were not appropriate for the resident's type of dialysis access and should not be on the care plan. She stated that the care plan is the plan of care of the patient needs so staff know how to care for the resident. RN #3 stated that a "fill-in" MDS nurse from another facility used a generic care plan and put in the wrong thing for this resident.

(B) The facility staff failed to ensure all medications and treatments were documented on the March 2021 and April 2021 Medication Administration Record (MAR).

A review of the clinical record revealed the following:

The March 2021 Medication Administration Record with the following medications that were not documented as being administered:

"Contact and Droplet Isolation....COVID-19, every shift for preventative for 14 days." This order was dated 3/21/21. The night shift (11PM to 7AM) failed to document this care on 3/24/21, 3/25/21, 3/28/21, 3/29/21, and 3/30/21.

"....Check Peg Tube for placement...." This order was dated 3/21/21 and was scheduled for every shift. The night shift (11PM to 7AM) failed to document this care on 3/24/21, 3/25/21, 3/28/21, 3/29/21, and 3/30/21.

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"....Elevate head of bed at least 30 degrees during feeding (tube feeding)...." This order was dated 3/21/21. The night shift (11PM to 7AM) failed to document this care on 3/24/21, 3/25/21, 3/28/21, 3/29/21, and 3/30/21.

"Enteral Feed Order, every shift, give Nepro 1.8 cal (calories) via peg tube at 45ml/hr (45 milliliters per hour)..." This order was dated 3/22/21 and was scheduled for every shift. The night shift (11PM to 7AM) failed to document this care on 3/23/21, 3/24/21, 3/25/21, 3/28/21, 3/29/21, and 3/30/21.

"Humalog (4)....per sliding scale...before meals for diabetes." This order was dated 3/22/21 and was scheduled for 6:30AM, 11:30AM, and 4:30PM. The night shift (11PM to 7AM) failed to document the blood sugar and dose of Humalog administered at 6:30AM on 3/23/21, 3/24/21, 3/25/21, 3/26/21, 3/28/21, 3/29/21, 3/30/21, and 3/31/21.

"Hydralazine (5)...50 mg (milligrams)....via Peg (Percutaneous endoscopic gastrostomy) -tube every 8 hours for HTN (high blood pressure)." This order was dated 3/21/21 and was scheduled for 6:00AM, 2:00PM, and 10:00PM. The night shift (11PM to 7AM) failed to document the Hydralazine was administered at 6:00AM on 3/23/21, 3/25/21, 3/26/21, 3/28/21, 3/29/21, 3/30/21, and 3/31/21.

"Sevelamer Carbonate (6)....Give 1 packet via Peg-tube before meals for renal disorder...." This order was dated 3/21/21 and was scheduled for 6:30AM, 11:30AM, and 4:30PM. The night shift (11PM to 7AM) failed to document the Sevelamer was administered at 6:00AM on 3/23/21, 3/24/21,

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3/25/21, 3/26/21, 3/28/21, 3/29/21, 3/30/21, and 3/31/21.

"Respiratory Screen every shift for 14 days document Yes or No for symptoms of COVID-19." This order was dated 3/21/21. The night shift (11PM to 7AM) failed to document this care on 3/23/21, 3/24/21, 3/25/21, 3/28/21, 3/29/21, and 3/30/21.

"Enteral Feed Order every 4 hours Flush Peg tube with 30 cc (equivalent to milliliters) of water." This order was dated 3/21/21. This was scheduled for 1:00AM, 5:00AM, 9:00AM, 1:00PM, 5:00PM, and 9:00PM. The night shift (11PM to 7AM) failed to document this care for the 1:00AM time on 3/30/21; and for the 5:00AM time on 3/23/21, 3/26/21, 3/28/21, 3/29/21, and 3/30/21.

The April 2021 Medication Administration Record with the following medications that were not documented as being administered:

"Nepro,....50c (sic - cc) (equivalent of millimeters) per hour from 7PM to 7AM daily." This order was dated 4/2/21 and was documented as being administered every evening. However, the night shift (11PM to 7AM shift) failed to document the Nepro was stopped around 7:00 AM on 3/2/21, 3/5/21, 3/6/21, 3/8/21, and 3/14/21.

"....Check Peg Tube for placement...." This order was dated 3/21/21 and was scheduled for every shift. The night shift (11PM to 7AM) failed to document this care on 4/5/21, 4/6/21, 4/8/21, and 4/14/21.

"....Elevate head of bed at least 30 degrees during feeding (tube feeding)...." This order was

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dated 3/21/21. The night shift (11PM to 7AM) failed to document this care on 4/2/21, 4/5/21, 4/6/21, 4/8/21, and 4/14/21.

"Humalog....per sliding scale...before meals for diabetes." This order was dated 3/22/21 and was scheduled for 6:30AM, 11:30AM, and 4:30PM. The night shift (11PM to 7AM) failed to document the blood sugar and dose of Humalog administered at 6:30AM on 4/2/21, 4/3/21, 4/6/21, 4/7/21, 4/9/21, 4/11/21, and 4/15/21.

"Hydralazine...50 mg (milligrams)....via Peg-tube every 8 hours for HTN (high blood pressure)." This order was dated 3/21/21 and was scheduled for 6:00AM, 2:00PM, and 10:00PM. The night shift (11PM to 7AM) failed to document the Hydralazine was administered at 6:00AM on 4/2/21, 4/3/21, 4/6/21, 4/7/21, 4/9/21, 4/11/21, and 4/15/21.

"Sevelamer Carbonate....Give 1 packet via Peg-tube before meals for renal disorder...." This order was dated 3/21/21 and was scheduled for 6:30AM, 11:30AM, and 4:30PM. The night shift (11PM to 7AM) failed to document the Sevelamer was administered at 6:00AM on 3/2/21, 3/6/21, and 3/7/21.

On 5/12/21 at 12:04 PM in a phone interview with LPN #9, who works the night shift with Resident #71, she stated that she checks the resident's blood sugars and sliding scale insulin, and the other identified medications and treatments. She stated that she forgot to document but that she always administers the medications/care/treatment.

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On 5/12/21 at 11:13 AM, ASM (Administrative Staff Member) #1, #2, #3, and #5 (the Administrator, the Director of Nursing, the Regional Director of Operations, and the Senior Clinical Transition Specialist) were made aware of the findings. No further information was provided.

References:

There are three types of dialysis access: temporary catheter (1)....and AV graft (2).

(1) Temporary Catheter: During this procedure, a thin flexible tube called a catheter is placed into a large vein in the neck. This catheter can be used a maximum of 3 months, so long term dialysis patients will require something else eventually. Also, because this catheter is placed directly into the bloodstream, there is a high risk of infection.

(2) AV graft: During this procedure, two small incisions are made in the arm and a cylinder like tube called a graft is inserted under the skin. One end of the graft is sewn to the artery and the other end to the vein. Again, this increases the size of the vein and it becomes tougher and thicker, with rapid blood flow from the artery to the vein.

(3) How Do I Know If the Graft Is Functioning Effectively?
There are two signs that indicate a dialysis access site is functioning well. When you slide your fingertips over the site you should feel a gentle vibration, which is called a "thrill." Another sign is when listening with a stethoscope a loud swishing noise will be heard called a "bruit." If both of these signs are present and normal, the graft is still in good condition. If not, there may be

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a narrowing within the graft as a result of blood clot collection. If there is bruising or discoloration close to the graft site, this could indicate that part of the graft wall was punctured and may require repair as well. The site may need to be reopened and repaired, or it may be possible to insert a thin flexible tube called a catheter through the site and use a balloon to widen the opening of the graft and improve blood flow.

Information obtained from https://www.vascularhealthclinics.org/institutes-divisions/vascular-surgery-and-medicine/dialysis-access/

(4) Humalog - is an insulin product used to treat diabetes.
Information obtained from https://medlineplus.gov/druginfo/meds/a697021.html

(5) Hydralazine - is used to treat high blood pressure.
Information obtained from https://medlineplus.gov/druginfo/meds/a682246.html

(6) Sevelamer - is used to control high blood levels of phosphorous in people with chronic kidney disease who are on dialysis.
Information obtained from https://medlineplus.gov/druginfo/meds/a601248.html

2. For Resident #333, the facility staff failed to ensure that another resident's information was not filed in Resident #333's medical record.

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Resident #333 was admitted to the facility on 2/15/21 and discharged to the hospital on 3/9/21 and did not return to the facility. The resident was admitted with the diagnoses of but not limited to left tibia fracture, pneumonia, obesity, diabetes, glaucoma, high blood pressure, chronic kidney disease, heart failure, end stage renal disease, dislocation of ankle joint, and dialysis. The 5-day MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/19/21 coded the resident as cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive assistance for transfers, dressing, toileting and hygiene; independent for eating; and was occasionally incontinent of bowel and bladder.

A nurse's note dated 3/9/21 at 2:00 PM documented, "Called MD (medical doctor) to notify him of the vital signs (temperature) 98.8, (blood pressure) 82/46, (pulse) 107, (oxygen saturation) level 89% on oxygen as ordered. Non-rebreather applied. Repeat (oxygen) level at 2:10pm is 75%. MD notified. Send patient out 911. RP (responsible party), daughter is aware."

Further review of the clinical record for the requirements related to hospital transfers revealed an item under the "Misc" (miscellaneous) tab where scanned documents are uploaded, that was dated 3/9/21 and titled "Written Notification sent", indicating this was the required written notification to the responsible party that was sent upon a hospital transfer.

When clicking on the above item to open it, the attached document was actually a "Screening for Mental Illness, Mental Retardation/Intellectual

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F 842	Continued From page 152 Disability, or Related Conditions" form that was completed for a different resident and uploaded into Resident #333's electronic medical record. On 5/12/21 at 9:15 AM an interview was conducted with OSM #3 (Other Staff Member) the Medical Records person. She stated that the item was not the transfer notice and should not have been in Resident #333's medical record. On 5/12/21 at 11:13 AM, ASM (Administrative Staff Member) #1, #2, #3, and #5 (the Administrator, the Director of Nursing, the Regional Director of Operations, and the Senior Clinical Transition Specialist) were made aware of the findings. No further information was provided.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880		6/15/21

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arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 154 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to follow infection control practices during wound care for two of 38 residents in the survey sample, Residents # 64 and # 18. 1. The facility staff failed to follow infection control practices by washing their hands before and after glove use and for a minimum of 20 seconds during Resident # 64's wound care. 2. The facility staff failed to disinfect scissors before use, wash their hands before and after glove use and failed to ensure handwashing for a minimum of 20 seconds during Resident # 18's wound care. The findings include: 1. Resident # 64 was admitted to the facility with diagnoses that included but were not limited to: heart disease, pressure ulcer and arthritis. Resident # 64's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 03/21/2021, coded Resident # 64 as scoring a 13 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 - being cognitively intact for making daily decisions. Section M "Skin Conditions)" coded Resident # 64 as having a pressure ulcer upon	F 880	Resident #64: the nurse that provided wound care was provided with 1:1 education on proper use of gloves during wound care and appropriate handwashing in general as well as with the use of gloves. No negative outcome occurred as a result of this practice. Resident #18: The nurse that provided wound care was provided with 1:1 education on how to sanitize reusable medical equipment and appropriate handwashing in general as well as with the use of gloves. No Negative outcome occurred as a result of this practice. Residents with pressure injury wound treatments are potentially at risk. Nursing administration completed hand washing competencies on staff. Licensed Nursing will complete education loaded into the electronic "Relias" learning system on Handwashing and Cleaning of Equipment and Surfaces. Nursing Administration will complete 5 wound treatment observations per week for 2 weeks and the 3 wound treatment observations per week for 2 weeks.	

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F 880	Continued From page 155	F 880	Corrections will be made as identified. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/designee to the Quality Assurance Committee. Continued compliance will be monitored through the quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

admission.

The facility's "Nursing Comprehensive Evaluation" for Resident # 64 dated 03/17/2021 documented in part, "Admission: 03/17/2021." Under section K. Skin" it documented, "Right Buttock. Stage 2 [1]."

The facility's "Braden Scale [2]" for Resident # 64 documented, "Effective Date: 03/17/2021. Score: 15. At Risk."

The most recent physician's order dated 05/02/2021 for Resident # 64 documented, "Wound Care: Sacral Wound - clean with NS - pack loosely with ¼ [one quarter] DAKINS [3] moistened gauze and PRN [as needed] - cover with dry dressing."

On 05/11/2021 at approximately 10:20 a.m., an observation was conducted of LPN [licensed practical nurse] # 4 conducting a dressing change on Resident # 64's sacrum [4]. Prior to the start of the wound care this surveyor introduced themselves to Resident # 64 and asked permission to have one of the female nurses of the survey team observe their wound care. Resident # 64 stated that it was ok with them that this surveyor conduct the observation because their doctor was a male. The wound care was observed by this surveyor in the presence of a female nurse of the survey team.

Resident # 64 was positioned on her left side with the assistance of CNA [certified nursing assistant] # 4 and a clean barrier sheet was set up over Resident # 64's over-the-bed-table after disinfecting it. LPN # 4 then placed the clean dressings and treatments on the

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over-the-bed-table. After donning a clean pair of gloves, LPN # 4 removed the old dressing, placed it in a trash bag, then removed their gloves, went to the sink and washed their hands. Observation revealed LPN #4's hand washing was completed in five seconds. LPN # 4 then put on a clean pair of gloves, cleaned the wound with normal saline, removed gloves, and immediately donned a clean pair of gloves without sanitizing or washing their hands. LPN #4 then applied the treatment and dressing, removed gloves, and donned a new pair of gloves without sanitizing or washing their hands. LPN # 4 then assisted CNA # 4 in repositioning and covering Resident # 64, removed gloves, went to the sink and washed their hands. The hand washing was observed to be completed in five seconds.

On 05/11/2021 at 11:35 a.m., an interview was conducted with LPN # 4. When asked to describe the procedure for hand washing LPN # 4 stated, "Turn on the water, wet hands, apply soap, suds hands and wash for 15 to 30 seconds, rinse hands, dry them with a paper towel then use it to turn the water off." When asked about the time frame of washing their hands, LPN # 4 stated, "I'm not sure." When asked to describe the procedure for washing hands when changing gloves, LPN # 4 stated that hands should be washed or sanitized before donning gloves and after removing them. LPN #4 was informed of the above observations of hand washing during Resident # 64's wound care procedure. LPN # 4 stated that they didn't use proper hand hygiene when washing their hands and before donning gloves and after removing them. LPN # 4 further stated, "I rushed through it."

The facility's policy "Hand Washing" documented

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in part, "I. C. Wash well under running water for a minimum of 20 seconds, using a rotary motion and friction."

The facility's policy "Using Gloves" documented in part, "II. E. Perform hand hygiene after removing gloves."

Per the CDC [Center for Disease Control and Prevention], "Multiple opportunities for hand hygiene may occur during a single care episode. Following are the clinical indications for hand hygiene: Use an Alcohol-Based Hand Sanitizer: Immediately before touching a patient, before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment, after contact with blood, body fluids or contaminated surfaces, immediately after glove removal. Wash with Soap and Water When hands are visibly soiled, after caring for a person with known or suspected infectious diarrhea and after known or suspected exposure to spores (e.g. B. anthracis, C difficile outbreaks).

The CDC Guideline for Hand Hygiene in Healthcare Settings recommends: When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. Use towel to turn off the faucet. Avoid using

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hot water, to prevent drying of skin. Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. Either time is acceptable. The focus should be on cleaning your hands at the right times.

Glove Use: When and How to Wear Gloves:
Wear gloves, according to Standard Precautions, when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin or contaminated equipment could occur.
Gloves are not a substitute for hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, before touching the patient or the patient environment. Perform hand hygiene immediately after removing gloves.
Change gloves and perform hand hygiene during patient care, if gloves become damaged, gloves become visibly soiled with blood or body fluids following a task, moving from work on a soiled body site to a clean body site on the same patient or if another clinical indication for hand hygiene occurs. Never wear the same pair of gloves in the care of more than one patient. Carefully remove gloves to prevent hand contamination."
This information was obtained from the website: https://www.cdc.gov/handhygiene/providers/index.html.

On 05/11/2021 at approximately 4:45 a.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, and ASM # 3, regional director of operations, were made aware of the above findings.

No further information was provided prior to exit.

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References:

[1]. Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis.Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence-associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions. This information was obtained from: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/

[2] The Braden Scale is a standardized tool to assess pressure ulcer risk. This information was obtained from the website: https://pubmed.ncbi.nlm.nih.gov/28512923/

[3] Used to prevent and treat skin and tissue infections that could result from cuts, scrapes and pressure sores. It is also used before and after surgery to prevent surgical wound infections. Dakin's solution is a type of hypochlorite solution. It is made from bleach that has been diluted and treated to decrease irritation. Chlorine, the active ingredient in Dakin's solution, is a strong antiseptic that kills most forms of bacteria and viruses. This information was obtained from the website: https://www.webmd.com/drugs/2/drug-62261/daki

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ns-solution/details.

[4] A shield-shaped bony structure that is located at the base of the lumbar vertebrae and that is connected to the pelvis. The sacrum forms the posterior pelvic wall and strengthens and stabilizes the pelvis. Joined at the very end of the sacrum are two to four tiny, partially fused vertebrae known as the coccyx or "tail bone". The coccyx provides slight support for the pelvic organs but actually is a bone of little use. This information was obtained from the website: https://medlineplus.gov/ency/imagepages/19464.htm

2. Resident # 18 was admitted to the facility with diagnoses that included but were not limited to: pressure ulcer and multiple sclerosis [1]. Resident # 18's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/12/2021, coded Resident # 18 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Section M "Skin Conditions)" coded Resident # 18 as having a pressure ulcer upon admission. Under "M0300" it documented, "Stage 3 - Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of the tissue loss. May include undermining and tunneling."

The facility's "Nursing Comprehensive Evaluation" for Resident # 18 dated 07/17/2019 documented in part, "Admission: 07/17/2019." Under section K. Skin" it documented, "Right

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Buttock. Stage 2. Left Buttock. Stage 2."

The facility's "Braden Scale" for Resident # 18 documented, "Effective Date: 03/17/2021. Score: 16. At Risk."

The current physician's wound care order dated 03/05/2021 for Resident # 18 documented, "cleanse sacral wound with NS apply hydrofera blue dressing [2] then dry dressing everyday."

On 05/11/2021 at approximately 10:35 a.m., an observation was conducted of LPN [licensed practical nurse] # 4 conducting a dressing change on Resident # 18's sacrum. Prior to the start of the wound care this surveyor introduced themselves to Resident # 18 and asked permission to have one of the female nurses of the survey team observe their wound care. Resident # 18 stated that it was ok with them that this surveyor conduct the observation because their doctor was a male. The wound care was observed by this surveyor in the presence of a female nurse of the survey team.

Resident # 18 was positioned on her left side with the assistance of CNA [certified nursing assistant] # 4 and a clean barrier sheet was set up over Resident # 18's over-the-bed-table after disinfecting it. LPN # 4 then placed the clean dressings and treatments on the over-the-bed-table. LPN # 4 reached into her lab coat and took out a pair of scissors and placed them on the over-the-bed-table without disinfecting the scissors. After donning a clean pair of gloves, LPN # 4 removed the old dressing, placed it in a trash bag and removed their gloves, went to the sink and washed their hands. Observation revealed LPN #4 completed

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handwashing in five seconds. LPN # 4 then put on a clean pair of gloves, cleaned the wound with normal saline, removed gloves, and immediately donned a clean pair of gloves without sanitizing or washing their hands. LPN # 4 then asked CNA # 4 to retrieve a bottle of peri wash. CNA # 4 removed their gloves, placed them in the trash bag, opened the door to the resident's room without washing their hands, and left the room. CNA # 4 then returned to the room with the bottle of peri wash and donned a clean pair of gloves. LPN #4 used the bottle of peri wash obtained by CNA #4, who was not observed washing their hands, and completed the procedure. LPN #4 then applied the treatment to the wound wearing the same gloves worn when handling the peri wash. LPN # 4 used the scissors they removed from their pocket, to cut the dressing to size without disinfecting them, and applied the dressing to Resident #18's sacral wound. LPN #4 then removed gloves, donned a new pair of gloves without sanitizing or washing their hands. LPN # 4 then assisted CNA # 4 in repositioning and covering Resident # 18, removed gloves, went to the sink and washed their hands. The hand washing was observed to be completed in five seconds.

On 05/11/2021 at 11:30 a.m., an interview was conducted with CNA # 4. When asked to describe the procedure for hand washing, CNA # 4 stated, "Turn on the water, wet hands, apply soap, rub hands together, wash the backs of your hands and between the fingers, rinse hands, dry them with a paper towel then use it to turn the water off." When asked to describe the procedure for washing hands when changing gloves, CNA # 4 stated that hands should be washed or sanitized before donning gloves and

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after removing them. CNA #4 was informed of the above observations of them removing their gloves and leaving the resident's room without washing their hands. CNA # 4 stated that they should have washed or sanitized their hands after removing the gloves before leaving the room.

On 05/11/2021 at 11:35 a.m., an interview was conducted with LPN # 4. When asked to describe the procedure for hand washing, LPN # 4 stated, "Turn on the water, wet hands, apply soap, suds hands and wash for 15 to 30 seconds, rinse hands, dry them with a paper towel then use it to turn the water off." When asked about the time frame of washing their hands, LPN # 4 stated, "I'm not sure." When asked to describe the procedure for washing hands when changing gloves, LPN # 4 stated that hands should be washed or sanitized before donning gloves and after removing them. LPN #4 was informed of the above observations of hand washing during Resident # 18's wound care procedure. LPN # 4 stated that they didn't use proper hand hygiene when washing their hands and before donning gloves and after removing them. LPN # 4 further stated, "I rushed through it." When asked if they disinfected the scissors used before cutting the dressing, LPN # 4 stated that they disinfected them before placing them in their pocket. When asked if the scissor were still disinfected after having them in their pocket, LPN # 4 stated, "I should have cleaned them when I took them out of my pocket."

On 05/10/2021 at approximately 9:50 a.m., during the entrance conference with ASM [administrative staff member] # 1, administrator and ASM # 2, director of nursing stated that the standard of practice the nursing staff follows was Lippincott."

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"Disinfection, noncritical patient care equipment. Introduction ...reusable noncritical patient care equipment should be disinfected after use, before use on another patient." Lippincott Procedures - Disinfection, noncritical patient care equipment. Revised: November 20, 2020.

"In a study conducted by the International Conference on Nosocomial and Healthcare related Infections in Atlanta Georgia, March 2000 showed that ordinary items can make your patients sick. In one study, a researcher gathered scissors that nurses and physicians kept in their pockets, as well as communal scissors left on dressing carts and tables. Three-quarters of the scissors carried microorganisms, including Staphylococcus aureus, Groups A and B streptococcus, and gram-negative bacilli. The solution is quite simple. If health care workers swab the scissors with alcohol after each use, they will virtually eliminate the risk of transmission of microorganisms. In the study, contaminated scissors were effectively disinfected after swabbing the scissors with alcohol." Reference: Embil JM, Dyck B, McLeod J, et al. Scissors as a potential source of nosocomial infection? Presented at the 4th Decennial International Conference on Nosocomial and Healthcare-Associated Infections. Atlanta; March 8, 2000.

On 05/11/2021 at approximately 4:45 a.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, and ASM # 3, regional director of operations, were made aware of the above findings.

No further information was provided prior to exit.

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F 880	Continued From page 165 [1] A nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. This information was obtained from the website: https://medlineplus.gov/multiplesclerosis.html. [2] Hydrofera Blue is a type of wound dressing. This information was obtained from the website: https://hydrofera.com/hydrofera-blue/	F 880		